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ORIGINAL DEPARTMENT.

LECTURE.

SHORTENING OF THE ROUND LIGAMENTS— "ALEXANDER'S OPERATION."

A CLINICAL DEMONSTRATION BEFORE THE SURGICAL
SECTION OF THE PHILADELPHIA POLYCLINIC,
OCTOBER 23, 1885.*

BY PROF. C. B. NANCREDE.

[Reported by Dr. A. B. HIRSH, Chief of Orthopaedic Clinic,
Philadelphia Polyclinic.]

GENTLEMEN: The facilities of this institution for the performance of rare and important operations are well demonstrated in the case which, among others, I hope to relieve before you to-day. As far as I am aware, only one successful Alexander's operation has been performed thus far in America, viz., one by Dr. R. Winslow, of Baltimore, although I have understood that another but unsuccessful attempt has been made in this city.

Prefacing my remarks by saying that Alexander shortens the round ligaments of the uterus for prolapse, retroversion, and retroversion combined with retroflexion of that organ, I shall in a general way describe what has been heretofore proposed for the relief of such malpositions, so that you may more readily comprehend what is claimed to be gained by the new method. You are well aware that great hopes were entertained when the operation for restoration of the perineum was introduced, and that it was thought that at length the means were in our hands of preventing or remedying obstinate cases of procidentia uteri, etc. Failure constantly resulting when the uterus

was enlarged, and thus heavier, from the gradual yielding of the new perineum, various modifications were introduced whereby a more solid structure was secured, and the lower part of or nearly the whole of the vaginal canal was narrowed. Numberless modifications of these plans have from time to time had an ephemeral reputation, but their results have too often proved but eventual failures.

Dr. Wm. Alexander, of Liverpool, seems at last to have supplied the great desideratum. It is now only about two years since he wrote his articles, and later his book, on "Shortening of the Round Ligaments of the Uterus." He claims that these structures are always lengthened in uterine displacements, whether backwards or downwards, and that by dissecting down to these ligaments and drawing them well out through the external abdominal ring, you can replace the uterus in its normal position; there to be maintained, not directly by the *shortened ligaments*, but by those natural means which in the healthy individual oppose uterine displacements. The long axis of the womb in its normal position cuts that of the vagina almost at a right angle. As long as this position is maintained, prolapse is impossible. The small intestines, by filling up the two pelvic compartments formed by the transverse curtain composed of the broad ligaments and uterus, maintain the womb in its normal position. The greater bulk of the small intestines, guided probably by the rectum, usually go behind the uterus; and as the round ligaments render the margins of the broad ligaments their tensest portion, even in the dead subject, and you will remember that the round ligaments are partly muscular, their laxer

* At the Episcopal Hospital.

portions are bellied forwards and backwards like a swelling sail, thus forcing the uterus either forwards and upwards, or less commonly slightly backwards and upwards; this, as Alexander says, "is by the hydraulic force of the enclosed intestines."

We will not here discuss whether this is a strictly scientific expression, but the fact remains. The tension of the margins of the broad ligaments, resulting from the relative shortness of the normal, or, after operation, the shortened round ligaments, in whatever direction the uterus is forced (whether forwards and upwards or backwards and upwards), always tends to slightly *antevert* the womb, i. e., thus insuring that the long axis of the organ is at right angles to that of the vagina.

As the patient is now nearly etherized, I must cut short my remarks, and refer you to Alexander's work for further argument and demonstration. No doubt, repairing a lacerated cervix, and thereby—or by other means—reducing the subinvolution, may be of benefit; but, unless you restore and keep restored the proper relation of the utero-vaginal axes, failure will almost certainly result. I believe, gentlemen, that when a bad case of prolapse or retroversion is permanently relieved by restoration of the perineum, it is because the solid new perineal body acts as a pessary does, and catching the cervix uteri, *anteverts*, and keeps antverted, the womb, i. e., restores the proper relation of the utero-vaginal axes. Finally, you should distinctly understand that the function of all the pelvic ligaments attached to the womb is essentially that of *balancing*, much as comparatively light guy-ropes keep upright the mast or derrick used for elevating building stone, or, as Alexander explains it, they act as the mooring lines from the stem and stern of a vessel, which securely retain it against a decided current, while yet they could not *sustain* for a second a tithe of the weight of that vessel. To reiterate, none of the uterine ligaments directly *hold up* the womb, but by directing the manner in which the intestines surround and act upon the womb, they enable the former to *sustain* this viscous.

It has been freely urged by theorists, especially among our British colleagues, who have failed to comprehend the true *modus operandi* of the new operation, that by absorption of the catgut sutures or yielding of the adhesions eventual failure must result, especially as these ligaments were not normally strong enough to sustain the uterus at first. We have tried to show that they never did nor are they after operation *expected* to

sustain the organ, but merely to enable the natural sustentation methods to again come into play.

Again, it has been objected that these ligaments are frequently impossible to find. Both sets of objections are purely theoretical, and no anatomist need fear failure. The procedure itself is of the simplest nature, the chief difficulty arising from the attempt to dissect out the ligaments when they consist of a number of bands, instead of boldly turning out the whole red fibro-fatty mass filling the inguinal canal. Alexander tells us* that in 100 autopsies, at all ages, and in 37 operations to date, he had never failed once to find the ligaments, although, where old intrapelvic inflammatory adhesions exist, it may, in rare instances, be impossible to *free* and *draw out* the ligament on one side, in which case he has found shortening one efficient against prolapse. In determining upon the advisability of an operation, especially for retroversion or retroflexion, the degree of mobility of the uterus should be ascertained by the sound.

The patient before you is a stout married woman, fifty-seven years old, of English birth, and mother of five living and numerous dead children. On account of a lacerated perineum and the uterine subinvolution consequent upon too early "getting up" after her rapidly-recurring labors, and also from her severe manual labor, a complete procidentia of the womb has taken place, so that the extruded uterus and everted vagina have assumed much the appearance of the male genitals, the mucous membrane from long exposure and friction resembling the external integument. Neither pessaries nor supports will any longer afford relief, and an operation of some kind is demanded.

Complete anæsthesia having been now induced, I cut freely down upon the right inguinal canal, taking the spine of the pubes on that side as my starting point, and prolonging my cut obliquely upwards and outwards about two and a half inches. Of course, the more frequently the surgeon repeats this operation the shorter will be the incision. On a thin subject, the incision need not be so long as I make it in this corpulent patient. Unless the surgeon has witnessed the performance of this operation more than once, it is advisable to practice it upon the cadaver. Following Alexander's directions, I hook out with an aneurism needle the mass of fibro fatty tissue from the external inguinal ring, after dividing a

* Annals of Surgery, May, 1885.

few of the intercolumnar fibres so as to freely open the canal. It may be well to say here that the external ring can be readily recognized after the aponeurosis of the external oblique has been freely exposed, by a little pellet of fatty tissue which bulges out from it. Having separated the fatty tissue with the finger-nail and a director from the sides of the canal, I recognize the ligament by the genito-crural nerve which runs along it, which latter structure I carefully separate, preferring not to cut it as Alexander advises, unless I see fit to do so at a later stage. Great care must be exercised not to fray out the ligament, only the finger-nail, closed blunt-pointed scissors, or a director being used—at least, this is my experience, although it is somewhat opposed to that of Alexander. You must proceed with care lest the peritoneum be opened, but there need be no fear of invaginating this serous sac into the canal, if the ligament be properly separated from its surrounding connections. Having dissected out both ligaments so that they play freely through their respective canals, I pass a stout catgut ligature successively through the ligament, the inner column of the ring, and the inner (upper) margin of the skin incision, repeating the same procedures on the outer column, etc., with a second thread. These sutures are then tied with sufficient firmness to retain the uterus, but not strangulate the ligament, the uterus, before they are tied, being replaced by a sound introduced into its cavity. The wound is now thoroughly syringed out with the mercuric bichloride solution, the surplus ligament tucked in, a capillary catgut drain secured to the bottom of the wound, which, after closure by a few points of interrupted suture, is dusted over with iodoform powder, and an antiseptic gauze dressing is applied.

In passing, let me beg you to observe the method I employ of inserting the catgut drain (a mere brush of catgut threads, as ordinarily used, always proving a snare): A bundle of some dozen or more fine catgut threads are tied together at its middle by another ligature threaded through a needle, by means of which the drain is securely stitched to the bottom of the cavity. Now, three or four strands brought out between each pair of silver sutures, the individual threads being kept closely in contact outside the wound, allow of capillary drainage. By the time discharge should have ceased—and remember, this form of drain is only effective for blood or serum, not pus—the gut within the wound is absorbed, and the remainder comes away with the dressings. The advantages of this method, introduced by Mr. J. Chiene, are

self-evident. Both ligaments are drawn up into position at the same time, so as to draw equally upon these structures, and held by an assistant while the sutures were passed. The left ligament as usual, you notice, is about half an inch longer than that of the right side.

Although, for safety, we employ antiseptic methods, we do not expect union by the first intention throughout. A medium-sized, well-fitting Smith-Hodge pessary is next introduced into the vagina, and the patient is placed in bed with her knees tied together and flexed over a pillow, and the head and shoulders somewhat raised to ensure relaxation of the abdominal parietes, thus avoiding any drag on the wounds. She will now have administered a hypodermic of morphia and be sent to the ward. You will notice before she goes, that the uterus is well raised up and strongly anteverted. Thus, even if the sutures should separate early, the newly-formed adhesions will be subjected to no dragging strain, since all expulsive efforts will only tend to still more anteverte the organ, drive it forwards, and rest it, as it were, upon the pubes, while by means of the loose broad ligaments, as before explained, the small intestines are allowed to crowd down below and actually *elevate* the womb. Please to remember that the rectocele and cystocele resulting from the torn perineum and relaxed, long-everted vagina, will not be cured, although, perhaps, materially improved, but the *womb* will no longer descend. Let us hope that by this new operation another opprobrium of medicine is removed, and a great advance in uterine therapeutics made, serving as another milestone on the forward journey of this century's remarkable advances in surgical science.

[Dr. Nancrede informed the reporter that the patient was doing well, but that, owing to the traction exercised upon the sides of the narrow wound, composed of lowly vitalized fatty tissue, some sloughs of cellulose-adipose tissue had come away, which rendered it impossible for portions of the wounds to close excepting by the granulating process.]

2130 Master street.

—Dr. Schjerning (*Viertelj. für Gerichtl. Med.*, Band xli., p. 273; Band xlii., p. 66,) has done good work by systematically collating the post-mortem experiences met with in a great number of cases of death from burns and scalds, under the heads of external lesions, lesions of the circulatory organs, of the respiratory organs, of the abdominal organs, and of the brain and cord respectively. This elaborate monograph is accompanied with a copious bibliography.

COMMUNICATIONS.

AMANITINE AND ITS ANTIDOTE.

BY CHARLES MCILVAINE,
Of Philadelphia.

The many cases of severe illness caused by toadstool eating, and the very general lack of knowledge as to the nature of the poisons producing them, as well as the proper treatment to be pursued as designated by the peculiar symptoms attaching to each poison of the several noxious varieties of toadstools, render it desirable that what is thus far ascertained about them should be widely published and known to the profession.

No physician called upon to give relief in a case of toadstool poisoning, can do so intelligently or be certain of success, unless he can distinguish from a sample of the toadstool eaten what particular poison is at work; or, from the symptoms, to which family of toadstools the illness is ascribable. With this knowledge in his possession, he holds the key to the situation, and by its use can stay the simple suffering produced by particular toadstools, or preserve his patient from what without it would be certain death if any of the deadly kinds have been eaten.

It is the duty of the mycologist to inform the physician how to distinguish between those varieties of toadstools which create simply local troubles in the human system, and those whose poisonous principles are absorbed by it to its destruction.

The toadstools likely to be eaten are, agarics (those having gills or plaits under their caps), polyporei and boleti (having tubes and sponge-like surfaces beneath their caps), hydnei (having spike-like projections underneath), clavaria (which are club-shaped or of coral forms, having thin spore-bearing membranes upon their upper surfaces), and lycoperdons or common puff-balls.

The hydnei and clavaria are nearly all edible. None of them are known to contain poisonous principles, but disturbances may arise from eating the tough and bitter varieties.

All of the puff-balls (lycoperdons) having white flesh are excellent, tender, and nutritious, so long as the flesh is white; but when the flesh changes from white to yellow upon being cut or broken, it becomes bitter and unpleasant to the taste, and in that and later stages of age or decomposition, eating of them would be likely to produce effects analogous to those from eating stale or rotten vegetables. Those puff-balls dark inside when young

(*scleroderma*) are not considered edible; neither is it determined that they are not. No authority brands them as noxious, but they are coarse and uninviting.

Of the boleti there are many luscious kinds; with mycophagists they are great favorites; by the community at large they are not so well known, and are at present rarely eaten in this country; in Europe they form a prominent article of food. Several varieties of them are supposed to be non-edible, and many well-versed writers pronounce them highly pernicious; yet every toadstool season careful experimenters remove suspected members of the family from the blacklist. There is no recorded case of death from toadstool-poisoning that has been traced to a boletus; but that some of them contain a bitter, acrid, or slimy principle, which is hurtful, but which yields to such ordinary remedial agents as are suggested by the symptoms, there is no doubt.

The noxious varieties of boleti, as a rule, are bitter, and all change color to red or blue when cut or broken; this change of color should not indicate to the physician that the boletus is poisonous unless it is accompanied by a distinctly bitter taste; it should, however, put him on his guard.

Of all the foregoing families of toadstools, it may be said that no recorded case of poisoning is ascribed to them. Every year the public journals chronicle deaths from toadstool eating, but they never mention what species of toadstool occasioned them. It would be of great practical value if—whenever possible—this information were given to the public, and fresh samples of the injurious fungus sent to some mycologist for positive identification.

Many toadstools—like most edible things—cause sickness, not because they contain an inherent poison, but for the reason that they are frequently overloaded with seasoning and rich additions—eaten in large quantities, when in an improper condition for food, owing to decomposition having set in—the leathery nature of some varieties, or want of sufficient cooking. Mr. Julius A. Palmer, of Boston, whose large experience makes him an authority upon the subject, advises the use of sweet oil and whisky, in equal proportions, in all cases where simply abdominal and intestinal derangements occur from toadstool eating.

The remaining family of toadstools, the agaricini, or gill-bearing, has more members than the sum of all the others of which individuals are eaten. To it belong the common mushrooms, *agaricus campestris*, and *agaricus arvensis*, to-

gether with many other members possessing high flavor and excellent qualities.

It is from this family that the masses gather for their tables, and in this family that real danger from toadstool poisoning exists. It contains a small genus consisting of about thirty members, known as *amanita*, eight of which are known to be edible, and at least five to contain a deadly alkaloid designated under the several names of muscarine, bulbosine, and amanitine.

This genus has distinguishing marks which cannot be mistaken, and should be known by every one. All of its members have gills which, with one exception, an edible variety having yellow gills—*amanita cæsarica*—are white at all stages of their growth. Their caps, which are convex, concave, or umbonate, generally show remains of an investing membrane existing as warts, scruff, or scales, which are easily removable by rubbing, and leave the smooth, satin-like skin intact. The flesh is white, tasteless, and almost scentless in young specimens. In older specimens, or soon after gathering, a strong unpleasant odor generates.

The caps range in color from the bright scarlet of the *amanita muscarius*, or poison-fly agaric, to the lemon-yellow of the *mappa*, and pure satiny white of the *bemus* and *phalloid*. Their stems are free from the gills, and are surrounded near the top with a kid-like apron or ring. At the base of the stem is a *bulb* which is covered with a sheath or *volva*. From this sheath or *volva* the poisonous *amanita* invariably springs. As the investing membrane, in the shape of warts, ring, or *volva*, is frequently evanescent, one or all may be absent in aged plants; but the *volva*, or remains of it, is almost universally found, if the plant is carefully removed from the ground. They grow in woods, uncultivated ground, on the margin of pastures near woods, in fence corners, and by their great resemblance when young to the common mushroom are frequently mistaken for it. The common mushroom never has a *volva*, and is seldom found in woods. It has pink or purple gills, and a much shorter stem than the *amanita*.

To Mr. Julius A. Palmer, of Boston, is due the segregation of the *amanita* group, and the pointing to it as the only one known to contain the subtle deadly alkaloid which is the subject of this article—amanitine.

In an article from his pen, contributed to the *Moniteur Scientifique*, of Paris, 1879, he says: "Mushrooms are unfit for food by decay, or other cause producing simply a disagreement with the system, by containing some bitter, acrid, or slimy

element, or by the presence of a wonderful and dangerous alkaloid which is absorbed in the intestinal canal. This alkaloid, so far as is known, is found only in the *amanita* family."

So long ago as 1868, Drs. Currie, Vigier, Smidberg, and Koppe, isolated this alkaloid, and it has formed a part of our pharmacopœia since that time.

The toxic properties of the *amanita* have long been known. The inhabitants of Northern Russia drink a decoction of, or eat the dried *amanita muscarius* (poison-fly agaric) for the purposes of narcotism and intoxication, and the urine of those who have partaken of it is in demand for future orgies, which are similar to those produced by alcohol.

M. Sicard, author of the "*Histoire Naturelle des Champignons Comestibles et Vénéneux*," Paris, 1883, experimented with amanitine upon dogs. He says: "Recently I have sought an appropriate antidote—an antidote of which the effects after absorption should be diametrically opposed in the system to those produced by the alkaloid of the mushroom—defined as an acrid and stupefying poison." After the absorption of the poison by a dog, M. Sicard, in following up his theory, injected subcutaneously two milligrammes of nitrate of pilocarpine, and a half hour afterwards a second injection with the same dose. After friction and the administration of five grammes of nitrate of potash dissolved in one hundred grammes of a solution of marshmallows, the dog recovered. "In strict truth," says M. Sicard, "I must say that the dog never recovered his normal condition; but the progress of the poison ceased, and he at least lived."

Dr. Gautier, in a work entitled "*Les Champignons*," Paris, 1884, says: "The use of atropine has been advised, not only to combat narcotic symptoms, such as those produced by opium poisoning, but as an antidote for muscarine—not yet perfectly isolated from the *amanita muscarius*." The experiments we have made upon animals in order to study the antagonism of atropine, and reciprocally, against the toxic elements of the *amanita bulbosus*, *amanita muscarius*, etc., have furnished negative results only. Yet it would be irrational to conclude that it lacked in efficacy upon man; and in all cases of poisoning by toadstools where nervous symptoms are manifested, it would be prudent to try the use of atropine in the dose of from $\frac{1}{4}$ to 0.002 of a milligramme.

The experience that we have reached in the search for an antidote against the action of the poisons of the *amanita*, *lactarius*, etc., by means

of the subcutaneous injection of many substances, have given equally of negative results. It is, however, important to continue these experiments, especially in the presence of the results obtained by Letellier. (The experiments of Letellier were confined to attempting the precipitation of the poison by the use of tannin.)

Experiments upon frogs were made with atropine, using it as the antidote for amanitine, and *vice versa*, with pronounced success; but not until August, 1885, was atropine successfully brought face to face with amanitine in the human system, as happened in the cases of toadstool poisoning in the Faris family, of Shenandoah, Pa., coming under the charge of Dr. S. E. Shadle, of that place, whose report will be found very valuable as indicating the symptoms of poisoning from eating of the *amanita vernus*, and the treatment pursued by him.

(To be continued.)

HOSPITAL REPORTS.

PHILADELPHIA HOSPITAL.

SERVICE OF DR. W. H. PARISH.

Latent Pelvic Peritonitis.

This colored woman was born in 1836; her menses, which were never profuse, ceased entirely two years ago. She was able to do hard work up to one year ago. She has been in the hospital for six weeks, and has been utterly incapacitated for two or three months, owing to severe pain all over the abdomen. She has much tenesmus, and occasionally voids clotted blood from the rectum. There is usually some rise of temperature in the evening, with a fall in the morning. The abdomen is very sensitive. She has received treatment for intestinal irritation, which undoubtedly exists, but as there must be a cause for this irritation, we will look for it. The abdomen is somewhat swollen and resonant. She complains of pain on defecation, and also at all times at the lower end of the rectum. There is probably a fissure and hemorrhoids, but they all depend on something else. She has had no children, her vagina is narrow, and the womb is low down, the cervix being felt one inch within the vulva; the cervix is tilted up against the symphysis pubis and the uterus is fixed in this position. Going back of the cervix, in the *cul-de-sac*, and trying to push up against the roof of the vagina, he meets with resistance; there is felt a hard mass extending back to the rectum and continuous with both sides of the vagina. By bimanual examination, the womb is found carried bodily forward, its anterior surface lying below the abdominal wall, and he finds an indurated mass extending up to the brim of the pelvis; over to the right, above Poupert's ligament, he can feel the upper border of the hard

mass by gently rolling the fingers over the surface.

The patient has lost flesh. The history of pelvic cellulitis is generally acute. In this case there is a combination of cellulitis and peritonitis, but this is not the whole trouble. Pelvic peritonitis may be rapid in its onset and course, or it may, as here, begin as a chronic affection, be latent and very gradual in its course. There may be, as here, very slight elevation of temperature. Cellulitis alone produces rather a globular swelling or tumor; there is not so much matting together of the parts as we have here. There are some symptoms in this case that point to cancer. The patient's mother died from cancer of the stomach, so that we have the factor of heredity; she has lost flesh, another sign-point pointing to cancer—the latency of the disease is also favorable to this view; against this supposition are the facts, that there is no *distinct* tumor, no discharge (from irritation) from the uterus, as is usual in cancer. Dr. P. believes that we have here a case of pelvic peritonitis, for which we can assign no cause. But we must remember that in some constitutions, very trivial causes will set up this trouble. There may be now a point of suppuration in this hardened mass. Such inflammations usually begin in the ovary or the Fallopian tube, and there may be pus there now. Dr. Parish made some remarks on the importance of always looking for a cause for symptoms, as oftentimes the symptoms are taken for the disease, and dire results ensue. Two weeks ago, in this hospital, a patient, who had been treated for *symptoms*, died from pelvic hæmatocele that was unsuspected. So many things are ascribed to hysteria, which, Dr. P. believes, always has a cause for its existence. In this case, if there is depression from any cause, the formation of pus is favored; the patient should be restricted from walking, being moved about in a carriage or wheeling-chair. Blisters and the local application of tincture of iodine should be resorted to. Hot water injections, with the patient on her back, should be used as long as they give comfort. She should have the best of food, and you must watch the bowels, as they are likely to be constipated from pressure. You must also look out for the bladder, as pressure may interfere with its evacuation, which fact may be present even though there is dribbling. He gives internally $\frac{1}{4}$ gr. corrosive sublimate and 5 gr. chloride ammonium in one drachm of compound infusion of gentian, to promote absorption. The prognosis is bad.

Prolapsus Uteri.

This woman has had three children and three miscarriages. She was operated on for lacerated cervix and prolapse and elongation of the intravaginal cervix. The lower end of the uterus protruded, while the body was nearly normal in position, so that the prolapse was not real, but only apparent. The lower end of the uterus, above the tear, was cut off. A circular incision was made around the cervix, flaps were dissected up from the external mucous membrane, and the cervix amputated, short flaps being made on the inside. The flaps were brought together and perfect union secured. These flaps obviated the liability of the cervix to close.

SERVICE OF DR. JOSEPH NEFF.

Peculiar Case of Typhoid Fever.

There is probably no disease the manifestations of which vary so much as do those of typhoid fever, and unless you are acquainted with this fact and bear it always in mind, you will be frequently in great doubt about coming to a diagnosis. This patient was taken sick with pain in his back, with cough and expectoration. The pain extended to his limbs and chest; he had a chill that lasted four hours, and on the same evening had epistaxis. The next morning his legs were swollen, the hip joint was stiff, and he had constant headache. The next day he was better. The following day, when he was in a station-house, he felt chilly about the feet, and on the succeeding day he was admitted to the hospital. He was then found to have fever, though he states that he had none for the two preceding days, though you cannot always take the patient's word for this. Only this morning a young man was in my office who said he had no fever, yet the thermometer registered 104°. On admission, at 6 p. m., his temperature was 105°, the next morning it dropped to 99°, and in the evening went up to 103½°. This is not the temperature of typhoid, and when taken in connection with the chills would point to remittent fever. There is not the typical expression of countenance, but we must remember that this is only observed in grave cases, and then not until the beginning of the second week. The spleen is enlarged, which would also point towards malarial fever, but we do have this enlargement in typhoid. We have, however, the typical eruption, which at once clears up the diagnosis. There was in this case a small patch of pneumonia, which did not increase and which was not extensive enough to account for the high temperature. In about thirty per cent. of all cases, typhoid commences with a chill. Dr. Neff thinks "typhoid" a very bad term; it describes a condition rather than a disease, and "enteric fever" would be much more definite and less misleading than "typhoid fever." This case is being treated on the specific plan; he is taking one drop of carbolic acid and two drops of tincture of iodine, well diluted, every three hours. Dr. Neff has been using this treatment for four years, during which time he has had some forty or fifty cases, with a mortality of six per cent., while the average mortality in this house is eighteen per cent. When the temperature keeps below 102° nothing else is done; when it goes above this point, the body is sponged with tepid water, uncovering only a portion of the body at a time, drying it immediately and covering it again. If it gets above 103°, he gives ten grains of antipyrine; if it remains above 103° for a day, he gives sixteen or twenty grains of quinine early in the day, on a falling temperature. If it reaches 104° or 105°, he gives twenty grains of antipyrine, and if this does not reduce it, he gives twenty more, ten more in half an hour, and at the end of the hour fifteen or twenty more, if required. When giving such large doses it must be carefully watched; but he has never seen bad results, even with such huge doses as one hundred and fifty grains in twenty-four hours; no collapse or chill, but copious

sweating. Typhoid fever, above all, calls for good nursing, hygiene, and common sense. If he were obliged to choose between a doctor and a good nurse, Dr. Neff would choose the latter. He formulates the following rules, to which he strictly adheres:

1. Always visit the patient twice a day.
2. At each visit listen to the lungs and percuss the bladder.

If patients object to his coming twice a day, he refuses to attend them.

Specific Anæmia.

While iron is the drug *par excellence* in anæmia, here is a case in which it is not called for; it would do good, but the improvement would be very slow. Mercury would be absolutely injurious. Iodide of potassium is the drug called for; two grains thrice daily, to be increased by one grain at a dose, until twenty grains are taken daily. We may make a saturated solution, so that we will avoid bulky dosage; one drop will represent one grain, and this will also render easy the gradual increase in quantity. With the iodide we may also use iron, giving the muriated tincture or the mallate. If the stomach revolts, we may give the iron hypodermically, using the ammoniated citrate or dialyzed iron, which is less apt to produce abscesses than the other forms. Dialyzed iron, however, Dr. Neff has found to be inert, and pins faith to it only in cases of arsenical poisoning, for it is a more stable preparation than the hydrated sesquioxide, and can therefore be kept.

SERVICE OF DR. J. WILLIAM WHITE.

Stricture.

Dr. White made some very practical remarks on the subject of stricture, noting that long continued gonorrhœa is much more apt to eventuate in stricture than short, sharp spells. When about to pass a filiform bougie, give the point a little bend with the fingers, for by so doing, and rotating the instrument as you pass it along, you will be much more likely to strike the opening which may be situated on one side of the stricture. While passing this bougie, he stops a few seconds to allow the subsidence of the spasm which its introduction has caused. When he has plenty of time to treat a stricture, he keeps the filiform in for a day or two, passes another alongside of it, and gradually dilates with metal sounds, allowing the man to keep up the dilatation by occasionally passing an instrument. This gradual dilatation, Dr. White decidedly prefers to any cutting operation. In private practice, if the man comes from a distance, he passes a Gouley catheter over the filiform bougie, sends him home and lets him come back again in a few days. He sees no necessity for country doctors to send their stricture cases to city surgeons; they can treat them just as well by this method of gradual dilatation, which requires chiefly patience and perseverance, but does not call for any great amount of skill. He always gives ten grains of quinine immediately after passing an instrument, and one-half drop of tincture of aconite every hour until bed-time on the day of the operation, to ward off urethral fever.

Suspected Chancere.

Here is a woman with a sore on her genitals. This sore has existed for a month; if it were specific, we ought, by this time, to have some enlargement of the lymphatics, but there is none. There is no induration about this sore. The chances are that it is local, but in such cases you should be careful not to commit yourself. *Remember that nothing will warrant the opinion of syphilis but syphilis itself.* Here is a man who has a sore. He was exposed to contagion one week and three weeks before its appearance. When feeling a sore for induration, always grasp it with a small piece of cotton, for your own protection. We may have herpetic sores, or friction, dirt, or smegma may raise suspicious ulcers. Never give constitutional treatment until syphilis is developed.

HOSPITAL OF THE UNIVERSITY OF
PENNSYLVANIA.

SERVICE OF DR. WILLIAM GOODELL.

Ruptured Perineum.

In bringing before the class a case that he had recently operated upon, Dr. Goodell took occasion to urge upon the class not to make *skin* perinei; they should be thick. A skin perineum will look well enough, but it will not afford support. To perform the operation properly, you must denude boldly, and dissecting a flap from the posterior wall of the vagina, unite it with the other tissue; this will give a perineum with the natural slope. When operating immediately after the labor at which the rupture has occurred, this, of course, will not be necessary, but we must then be careful to plunge the needles deeply, to do which we must have a good light; candle-light will hardly answer. This woman was operated upon one week ago. He amputated the cervix and sewed up the perineum; he now takes out the stitches and finds good union. When the sphincter is not torn, there is no necessity to draw the water—the urine is usually bland, and will do no harm; though, when convenient, he prefers to draw it. To remove the stitches, he places the woman on her back, while an assistant holds aloof her legs, that are tied together. It is always well to move the bowels before removing the sutures. In a couple of days he will loosen the legs, that have been tied together since the operation.

Mammary Abscess.

This is a particularly interesting case, because it affords me the opportunity of speaking upon a very important and very practical question. This woman has two sinuses, the result of a mammary abscess, but as she has also some uterine trouble, we will take that up first. She is 24 years old, has had three children, the youngest of whom is now three years old, and one miscarriage, which occurred last September, and she has not been well since. She complains of dysuria, with pain in the epigastrium and both iliac regions. She menstruates every three weeks, and the flow lasts for two weeks. The age of the patient would militate against a fibroid, and it is not likely that there is a polypus, as they rarely occur in child-bearing women; carcinoma is very unusual at this early age. So, by a process of exclusion, we

bring it down to a possibility of two conditions: sub-involution, which is liable to occur after miscarriage. Involution is a process of fatty degeneration, the contracting womb exerts a pressure on the blood-vessels, not enough to cause necrosis, but sufficient to interfere with the full nutrition of the large uterus, and it suffers fatty degeneration in consequence. Occasionally this interference is so great as to cause necrosis, but he has never seen it do so unless there was a fibroid, and in such cases death generally ensues from septic poisoning. Another possibility is that this womb may contain vegetations. He asks her what she thinks was the cause of the miscarriage; she replies that she attributed it to heavy lifting in moving, a very common cause. Whenever you encounter a woman with a history of repeated miscarriages, no matter howsoever exalted her position, no matter how high above reproach she may stand, no matter what may be the nature of her surroundings and conditions, you can rest assured that the trouble is due to syphilis, and that specific treatment is imperatively called for. This woman has had only one miscarriage. Upon examination he finds endometritis, metritis, and the sound passes in more than three inches, demonstrating that we have here sub-involution. If you think that you are going to reduce a three-and-a-half-inch womb to two and a half inches, you will be most grievously disappointed. By proper treatment you can reduce it to minus three, but below this you will not go. You may apply tincture of iodine, made stronger by the addition of metallic iodine or carbolic acid, Calvert's No. 4 (some prefer commercial carbolic acid, but Dr. G. thinks it offensive, and does not think it possesses any virtue over the Calvert's No. 4). You must teach the woman how to apply these drugs on a tampon. Take a piece of cotton (*non absorbent*, for absorbent cotton will allow the fluids to pass through too quickly) about the size of your hand (it must be the best cotton, with the fewest seeds), lay it on the palm of the hand, and pour into the centre one drachm of a glycerole (of whatever drug you may use), bring the edges together, tie tightly with strong twine, cut off the redundant cotton beyond the twine, push well up to the cervix, let remain for twenty-four hours, remove, and insert a new one. After several applications, discontinue them, and wait awhile to see what effect has been produced; the woman may become pregnant, and this may do more good than anything else. For these glyceroles we may use tannin, sulphate of zinc, acetate of lead, or salicylic acid. This last is very good, save that it sometimes produces great itching, unless the parts are well greased with vaseline. This method of making applications is far better than any other, except when we are using very strong drugs, when the constant application would be too severe. This case will be thus treated, and the woman will wear a pessary. When the womb is felt in the lumen of the pessary, you know that it is in position. If it is not there, introduce a sound and gently lift it into position. The pessary may be too small; if so, the one first introduced will distend the vagina, and in a day or two you can introduce a larger one.

We will now go on to the mammary trouble, and I will tell you most emphatically that it is an

erroneous superstition that mammary abscesses occur when a woman loses her child; such women rarely have abscesses unless the doctor causes them. The breast may look like it, may be angry and inflamed; but if you give support to it, keep the bowels open, give opium, and if necessary draw off a little of the milk, there will be no further trouble. It is a sore nipple that causes abscess, hence Dr. Goodell thinks that the trouble is septic in its origin. He speaks authoritatively on this subject, for he has had great experience in this line; but since he received his present convictions and acted on them, he seldom has abscesses. You will often read of the good effects of belladonna and iodide of potassium in preventing mammary abscess after a woman has lost her child, while in reality the abscess did not form, because the woman did not have a sore nipple. He never uses belladonna now, because it is dirty and is useless. As a placebo he will, if necessary, apply camphorated alcohol. The milk can best be removed by a friend, or better, by another baby, for the suction of the baby has a double action, that of the gums as well as the lips. A woman can suck her own breast through a common clay pipe. In this woman the abscess occurred four years ago. On this side she had a small, depressed nipple. When the abscess healed, cicatricial tissue drew the tissue of the gland together, but it failed to do so entirely, hence we have these two sinuses, lined with a pyogenic membrane, that will go on secreting pus until doomsday, unless something is done for her. We will operate on her next week (our next issue will report the operation). She is now taking what is known in this hospital as the "four chlorides," a most excellent tonic:

B. Hydrarg. bichlor.,	gr. j.
Liq. arsenici chlor.,	gtt. l.
Tinct. ferri chlor.	
Acid. hydrochlor. dil.,	āā f. $\frac{3}{4}$ iv.
Syr. zingib., ad.	f. $\frac{3}{4}$ vj.

M. S.—Dessertspoonful at a dose.

To please the patients and friends, we may apply something to the breast when mammary abscess is threatened, but it is not necessary. In these cases the ounce of prevention is the great thing. If a woman has a depressed nipple, it should be drawn out; and this can best be done by taking a bottle, the mouth of which fits nicely over the nipple, heat in hot water and adjust over the nipple—as the air in the bottle cools, it exerts a suction force on the nipple and draws it out; this may be done several times daily.

The question of the treatment of cracked nipples, which is the cause of abscess, is a very thorny one, because it is necessary to remove the child from the breast, and in the majority of cases this is impracticable. If this cannot be done, the intervals of nursing must be lengthened. To a disinterested observer, a cracked nipple seems like a very insignificant affair; but, like a fissure of the anus, it is excruciatingly painful, and to the child is a serious matter, as it may suck out and swallow considerable quantities of blood, which it afterwards throws up.

Dr. Goodell has lately been using cocaine in from a two to a four per cent. solution; this allays the pain, but he has not been using it

long enough to venture a positive opinion on its merit. The crack may be touched lightly with solid caustic or a strong solution of nitrate of silver. Taken all in all, iodoform ointment (3j. to viij. of vaseline) is probably the best application. He prefers the ointment to the powder, as the crystals in the latter will injure the tissue. Iodoform is not poisonous, so that the child can take the breast, but it is well always to remove the iodoform previous to nursing; but do not rub it off, pat it off. You will have to change from one application to another. Nitrate of lead (gr. x. to xx. to 3j. of glycerine) is good. The crack can be closed with collodion and tannin, 3j. to 3j., and it may remain closed while the child is nursing, but this does not often happen. We may use a saturated solution of boracic acid, or a glycerole of tannin. Lead may possibly poison the child. It may be necessary to give opium or bromide of potassium, and in this way we will generally get along without an abscess; but they will sometimes form in spite of us. The first symptoms of a forming abscess are a chill down the back, with a glazed, glistering appearance of the breast, which pits slightly. We should at once give quinine, from twelve to sixteen grains daily, and cover the breast with a large poultice, in which we should incorporate some landanum.

We must open as soon we are sure of the presence of pus. We will discover the presence of pus by pressing over the breast here and there; where the pus is it will feel sensitive and as though there were a well under the skin. When you come to open, remember how the ducts run, out from the nipple, like the spokes of a wheel, and do not cut crosswise, else you will cut several of them and produce lacteal fistulae. Cut between the spokes. It is a good plan always to give ether. Most young men make their incisions too small; they must be free—at least one inch long. He has never opened an abscess under the spray; he might do so now, but he has not had one for a long time. The cavity should be syringed out with a two and a half per cent. solution of carbolic acid. Poultice till the discharge becomes thin, then stop, as further poulticing only keeps up the discharge; then strap the breast, strapping upward over the shoulder and downward under the arm, putting in a drainage tube. If it is slow in healing, take a five to ten per cent. solution of carbolic acid, place the nozzle of a syringe in the orifice and inject forcibly, so as to distend the abscess, and then strap. If you cannot detect pus, but you are sure, from other signs, that an abscess is forming low down, nick the skin on the lower edge of the breast and tissue beneath, and pass down a probe or uterine sound, then pass a uterine dilator and open it—this will give free vent to the pus; then put in a drainage tube and use carbolic injections daily after the pus becomes thin. When you do not etherize, always try to open the abscess without the patient's knowledge, conceal the knife in your hand, and do not let her know what you are going to do. When Dr. Goodell was practicing in a small town, before coming to Philadelphia, he acquired quite a reputation for his tricks in opening mammary abscesses. He was once sent for by a woman, who warned him that she had heard of his tricks, and that he could not cut her without her knowledge.

He had his lancet concealed in his hand, but she watched his every movement so closely that he almost despaired of being able to fool her, when suddenly he said, "Nurse, are you not afraid those clothes so near the stove will take fire?" The patient involuntarily turned her head, and without her knowledge the abscess was opened.

SERVICE OF DR. D. HAYES AGNEW.

Sarcoma.

This man, 23 years old, some six or eight months ago, was making a muscular effort, with his arms elevated, when he felt something give way. One or two months later a swelling appeared over the left deltoid, which has increased rapidly. It is underneath the deltoid. The skin is not red, and there is no implication of the axillary glands. He has completely lost the power of elevating the arm. We take this to be a sarcoma, from the age of the patient, its following an injury, its rapid growth, absence of chills, want of redness of skin, non-adherence of skin to tumor, and the soundness of the skin, all of which is very different in carcinoma. In most of these cases it is necessary to amputate, but there is here so much objection to this procedure that we try a more conservative plan. He makes an incision, as for amputation, on the outer aspect of the arm, dissects up the flap, disarticulates the humerus, and saws off the diseased mass.

MEDICAL SOCIETIES.

PHILADELPHIA NEUROLOGICAL SOCIETY.

A stated meeting of the Society was held Monday evening, October 26, 1885, the Vice-President, Dr. Charles K. Mills, in the chair.

The first paper read was entitled

Hyoscine Hydrobromate,

By Henry M. Wetherill, Jr., M. D.

We do not, as yet, know accurately the history of the discovery and introduction of this most important and valuable therapeutic agent; but certain it is that Landenberg, of Germany, was the discoverer of hyoscine and the first to investigate its properties. His observations were seconded by those of Edelfsen, Gnauck, Emmert, and others on the Continent. The English current medical literature has, I think, not made mention of it. To Dr. Horatio C. Wood belongs the credit of being one of the first to investigate its action in this country, as seen in his admirable monograph published a few months since.

It is said that hyoscine is prepared by a rather complicated process from the alkaloid hyoscyamine by treating the latter with baryta-water. The pure alkaloid hyoscine is so volatile and perishable that it is never available as a therapeutic agent unless combined with acids, which form with it salts of fair stability. Those at present found in the drug market are the hydriodate, hydrobromate, muriate, and, I think, the sulphate. My experience has been wholly with the hydrobromate, and it is this salt alone of which this paper treats. The most reliable is that produced by E. Merck, of

Darmstadt, whose three accredited agents in New York are Lehn & Fink, Schieffelin & Co., and Eimer & Amend. It can be obtained of the leading pharmacists of this city. In its gross physical appearance it resembles small crystalline masses and granules of potassium bromide. It is light in relative weight, opaque white, but not purely so, slightly inclining to be yellowish, rather deliquescent when exposed to the air. Seen under the microscope, it was very evident that its crystallization had been facilitated by stirring, as much of it was in very irregular granular masses; but when allowed to evaporate spontaneously from its aqueous solution, it showed under the microscope handsome quadrilateral crystals springing from a granular base. These were entirely free from extraneous matters, transparent and highly refractive. The literature of hyoscine is rather meagre in America; brief notices of it are to be found in the more recent works on therapeutics and materia medica. The other works devoted to this subject are Dr. Wood's monograph, the paper by Dr. Judson B. Andrews found in the *American Journal of Insanity* for October, 1885, a paper emanating from the Hudson River Hospital for Insane, in the *New York Medical Record*, 1885, and some papers from the pen of Prof. John M. Maisch in the *Philadelphia Journal of Pharmacy* for November, 1885.

Hyoscine hydrobromate is freely soluble in cold distilled water; but it will be found desirable to add to this menstruum ten per cent. of alcohol as a preservative. The following I have found to be a convenient formula:

B. Hyoscine hydrobrom.,	gr. j.
Aqua destillat.,	f. ʒ ix.
Alcohol,	f. ʒ j.

In every ten minims of this solution there is $\frac{1}{10}$ of a grain of the hyoscine hydrobromate. In prescribing the compounds of hyoscine care should be used in writing the name of the salt in full and plainly, so as not to mislead the pharmacist with the impression that hyoscyamine has been ordered, and *vice versa*, as the hyoscine salts are far more powerful than are those of its sister alkaloid. Now thus having described the substance at some length, what have we found to be its exact physiological effects, and what do we find to be its true place in therapeutics after a very careful and painstaking study of its action, which has extended over a period of six months upon the patients under our care in the Pennsylvania Hospital for the Insane? Before answering this question, let me recount the effect produced upon myself by a very moderate dose taken by the mouth. I was in health at the time. Dose, $\frac{1}{15}$ of a grain. Before administration, pupils normal, equal; pulse 88, good; respiration 20 per minute; skin normal; temperature 98° F. Within 45 minutes, the pupils were evenly and moderately dilated, the voice was hoarse, face suffused, conjunctive injected, temperature raised to 99.5° F., respiration full, slowed to 16 per minute, pulse slowed to 64, very full, considerable general relaxation of muscles, decided general sweat, impaired coördination, and a sense of fullness in the head and of wretchedness. I managed somehow to get to bed, and at once fell asleep, and so continued for nine hours. Awoke much refreshed,

no ill effects, everything normal but the pupils, which were yet slightly dilated, but which regained normal conditions within two hours.

Now, in regard to our results as obtained by its use in the hospital. We have no hesitation in saying that as a hypnotic and sedative it has proved most valuable in our hands. As a hypnotic the usual range of dose is from $\frac{1}{150}$ to $\frac{1}{50}$ of a grain given at bedtime, preferably by the mouth—very frequently a less dose than gr. $\frac{1}{150}$ will be sufficient; gr. $\frac{1}{200}$ has often acted better in insomnia than has a larger quantity. It is very seldom necessary to repeat the dose; and another very decided advantage possessed by hyoscyne over hyoscyamine is that small doses can be continued for a long time without increase, whereas the patient soon tolerates small and then moderate quantities of hyoscyamine, and finally resists even very large doses of it. We have given hyoscyne a thorough trial in the insomnia occurring in the course of acute delirious mania, and with marked success, having succeeded, when all the usual modes of treatment had proved inadequate, in securing for the patient from six to ten hours of quiet sleep nightly for the past nine weeks, with but four or five exceptions; but one dose in every twenty-four, at bedtime, the amount ranging from gr. $\frac{1}{150}$ to $\frac{1}{50}$. The insomnia in these cases is one of their chief elements of danger. If it is possible to give such a case a fair amount of sleep and of nourishment in a concentrated form, the probability of a favorable issue might be entertained. The insomnia of agitated melancholia, of the morphia habit, of alcoholism, of acute mania, of neurasthenia, of chronic mental disorder, with habitual wakefulness and motor activity, and in those confirmed cases of insomnia from unascertained cause which usually prove so obnoxious to treatment, hyoscyne has been found to answer a very good purpose. It does not invariably succeed; but the failures have been very exceptional. In many instances the chronic insomniac habit has been broken so as to permit of the withdrawal of the hypnotic. It is a severe test of the value of any hypnotic to administer it in daytime, and the drug under consideration has been found to act very well even under this condition. It seems scarcely necessary to refer to the unsatisfactory and often disappointing action of the hypnotics which are now in general use, and it would seem as though this remedy is the one for which rational therapists have waited for so long a time.

Now, as to its usefulness as a general sedative, we have had results which justify the assertion that it is the very best means at present at our disposal for calming the motor excitement of acute and chronic mental disorders, in their talkative, active, noisy, destructive, or violent phases. In this class of cases the range of doses may sometimes have to be greater than in the treatment of insomnia, from gr. $\frac{1}{150}$ to $\frac{1}{50}$. I have seldom been obliged to give so much as gr. $\frac{1}{50}$, and have rarely had to give more than one dose in twenty-four hours. As an occasional exception a patient has been found whose excitement has successfully resisted a full dose; but it must be remembered that some cases of chronic mental excitement have been dosed with varying success through a period of years, until a peculiar condition of resistance to, and toleration of, remedies of this class has

become established. Where a large number of excited patients are congregated, even though they may be classified with care, there are a few who seem to be the cause of most of the general disorder and confusion; reduce these few to a condition of comparative quiet, and the larger, but less aggressive, element remains tranquil. Following out this theory in the administration of hyoscyne, we have had the satisfaction of seeing wards for excited patients quite transformed in character for the better; nor can this be fairly termed "medical restraint."

I have tabulated carefully our study of the physiological action of this remedy as a hypnotic and as a sedative, and have also tabulated our experience with hyoscyamine as a hypnotic. We had found the latter so decidedly inferior to hyoscyne as a sedative that it was not deemed necessary to tabulate these results; but it must not be inferred from this that hyoscyamine is inert. It is a remedy of no mean value, and only second in activity to its sister alkaloid.

The tabulated statements to which reference has been made will appear in the forthcoming Report of the Committee on Lunacy of the Pennsylvania State Board of Charities for 1885.

Physiological Effects.—The physiological effect of a full dose of hyoscyne, say gr. $\frac{1}{50}$, is manifested within twenty minutes. These are brief, transitory bewilderment, marked interference with coördination, widely dilated pupils, slow, regular, very full pulse, dryness of the throat, relaxation of the vocal cords, very slow, full respirations, sometimes becoming Cheyne-Stokes, marked suffusion of the face and of the general surface of the body, a slight rise in temperature, and free diaphoresis, which does not seem to restore normal temperature. There is general muscular relaxation, and a sense of wretchedness. Sleep usually follows, which continues from one to five hours, if the dose is given in daytime and the patient is not put to bed. This amount administered at night would be followed by sleep lasting for eight or ten hours. The midriatic effect is rather transient, but usually persists through an entire day. The pulse is slowed about twenty beats per minute, and this effect gradually wears away during eight or ten hours, and is often followed by a very variable period of pulse acceleration, which seems to be simply a reactionary hastening of the pulse to restore the disturbed balance of the circulation. The normal rate of respiration is gradually restored through a period ranging from three to five hours.

The rise in temperature is not an invariable result, and is frequently small—seldom exceeding one and one-half degrees—and the balance of temperature is usually restored within two or three hours. Dryness of the throat often persists through an entire day. Suffusion of the surface of the body is usually transitory. In moderate and in small doses the effect is, of course, proportionate to the amount employed; but the same general symptoms are present and the patient is quieted accordingly. Interference with the appetite is sometimes observed. It does not seem to act upon the bowels nor upon the kidneys.

Hyoscyne is not always well-borne; occasionally the following symptoms have followed the

use of a moderate dose: Nausea, vomiting, anorexia, dysuria, syncope, with small, rapid, irregular pulse, and with symptoms of partial paralysis of the pneumogastrics. This untoward condition occurred in a case of epileptic mania, in one of parietic dementia, in one of chronic dementia with excitement, and in one of acute hysterical mania. All of my personal experience of the action of hyoscine has been among females, and they are, I think, more susceptible to its action than are males. This is generally true of many drugs. Hyoscine is a spinal sedative of considerable activity. It had a decided influence over the spasms of a case of tetanus; a powerful man, whose life it certainly prolonged for some hours, and who died, not from convulsions, but from high temperature—this was, I think, 108° F. before death; but post-mortem, it rose to 116° F. This case was not mine, but I know that the observations were accurately taken with a corrected thermometer. Is it best to give the remedy hypodermically or by the mouth? It acts almost immediately, and in rather less dose, by the former method; yet we have preferred usually to give it by the mouth, as it acts very promptly when taken into the stomach, even in very small doses, and this method offers no shock to an excited or timorous patient.

Among the physiological effects of hyoscine, one or two observers claim to have frequently noticed a primary acceleration of the pulse-rate, previous to its becoming slow and full. This I have not found to be the case save in two instances, and even in these two cases the effect was not invariable. There is a source of possible error to be here taken into consideration—that the mere act of feeling the pulse, or even addressing some persons, causes a marked acceleration of the pulse, which may persist for some time should the patient be excited, timorous, apprehensive, or nervous.

From three observers of the action of hyoscine in another state, comes the report that their anticipations of the good effects of the drug had not been realized, after fair trial of an article which they thought was reliable; but there is some reasonable ground for doubt that the substance employed emanated from Merck's laboratory. The evidence that it is a hypnotic and sedative of great value to the profession is rapidly accumulating. We have thus far found the different samples of Merck's hyoscine hydrobromate to be uniform in effect and in external characteristics, and are much pleased with its action. It has been in daily use and under close observation in our hospital practice, and we prescribe it with confidence in its activity. It is preferable to the other sedatives and hypnotics, as it is more certain and uniform in effect, convenient in administration, and free from injurious secondary effects.

The discussion on Dr. Wetherill's paper was opened by Dr. D. D. Richardson, who said it had been his experience to find that hyoscine caused dilatation of the pupils. In some cases the pupils remain dilated for a few days, but as a rule it disappeared sooner. The pulse was always much increased; with the exception of one case it was always above 120. Respiration increased often to 40 per minute. He agreed with Dr. Wetherill as regards rise of temperature and increased respira-

tion. The appetite is not influenced by the use of the drug. The secretions, he said, were generally increased, especially the kidneys. No constipation resulted from its use.

Dr. Chapin said he had been a daily observer of the experiments of Dr. Wetherill, and entirely concurred with his remarks. He said he had always found the pulse to be hurried. The sleep which resulted from its use has been from eight to ten hours. He thought the difference of opinion of the physiological actions of the drug might be due to different preparations of it.

Dr. Wetherill, in conclusion, said that the dryness of the throat was very decided. There was also a relaxation of the muscles of the throat.

The next paper read was entitled, "The Principles Governing a Choice of Currents in Electro-Therapeutics," by G. Betton Massey, M. D.

The reader pointed out the value of more accurate conceptions of the differences in the physical character of faradaic and galvanic currents as a basis for their intelligent selection. The therapeutic value of faradism is due entirely to its electromotive pressure, while the most useful medical quality of the galvanic current is its volume.

Electromotive pressure and electric volume are essentially different articles of the materia medica, and should be so considered.

The therapeutics of "volt-pressure" applications were reviewed, including the differing indications for slow-succession and rapid succession faradaic currents, and were contrasted with the therapeutics of "milliampère-volume" applications.

The paper concluded with the statement that the faradaic current presents the best form of electricity for the treatment of those diseases in which a stimulation of mobility or sensibility is either directly or indirectly curative, with the single exception of disorders characterized by the appearance of degenerative response, while the constant galvanic current may be relied upon to fulfill the remaining possibilities of electricity in medicine.

LEWIS BRINTON, M. D., Recorder.

CINCINNATI ACADEMY OF MEDICINE.

Stated meeting, October 19, 1885.

President, Samuel Nickles, M. D.

Secretary, G. A. Fackler, M. D.

Dr. Robert W. Stewart reported a case of

Gonorrhoeal Rheumatism.

The following were given as characteristic symptoms of gonorrhoeal rheumatism:

1. It is usually antipyretic or of low degree.
2. Generally confined to one joint, most often the knee.
3. The pain is also less severe than in acute articular rheumatism.
4. There is a marked tendency to hydrarthrosis.
5. There is not the profuse sweating of acute articular rheumatism.
6. The inflammatory buffy coat is not present.
7. An ophthalmia is a common concomitant of the rheumatism.

Discussion on Rupture of Membrana Tympani.

(See page 654.)

Dr. G. W. Tangeman, in discussing the paper of Dr. Ravogli, said that the subject of rupture

of the membrana tympani has always been an interesting study, more possibly on account of the causes producing this disturbance than on account of the treatment the injury requires. Nature herself has done a great deal toward protecting this structure. In the first place, its oblique position to the auditory meatus; secondly, the so-called membrana placida, or the membrane of Schnappell, which yields when undue pressure is brought to bear upon it. From my own experience and the reports of others, few if any membrana tympani are ruptured—the injury due to explosions or violent movements of the atmosphere which forces the air with undue pressure on to the membrane—unless this structure or some portions of the ear were in a pathological condition. Condensed air has caused rupture of the membrana tympani.

In laying the foundations for large bridges, or digging tunnels under rivers, men are compelled to pass through or work in an atmosphere of condensed air amounting to from 35 to 50 pounds to the square inch above the normal. In these cases rupture was produced by pressure direct on the membrane, as was clearly proven by Dr. Magnus in his studies of the ear in condensed air. Drs. Smith and Green report cases verifying the statement that even in condensed air the drum-head is safe when the Eustachian tubes and middle ear are in a normal condition. But there is another class of cases which interests us more, viz., where the membrane is injured by injuries to the head. The first case that I observed coming under this class was in private practice. Mr. B. struck his wife a sudden blow on the ear with the palm of his hand. The blow was given with such force that the woman fell unconscious to the floor. In the course of a few hours she complained of fullness on the side of the head and loss of hearing. On examination, I found a rent anterior to the handle of the malleolus, fully one line in length, through which the patient could force air by the Valsalvian method. The watch could be heard about two inches from the head. When the ears were inflated by means of the catheter, the air did not pass through the tube very readily. Besides, there were other symptoms that indicated an abnormal condition of the Eustachian tubes, showing a pathological condition prior to the receipt of the injury. The treatment in the case really amounted to nothing, save a few careful inflations. In the course of a few days all sources of irritation and redness of the membrane disappeared, and hearing gradually improved.

The second case was one that came under my observation in the Eye and Ear Clinic, Medical College of Ohio. It was the case of the assistant chief of the fire department. This case is quite unique. The chief was giving orders to the hose-men in regard to the direction in which a stream of water should be thrown at a fire. The nozzle was quickly turned, but in so doing the full stream from a larger hose struck him on the left ear, knocking him off his feet. He claimed he could feel the water passing down into his mouth and nose through the Eustachian tube, which might have been the case, since in a few days a purulent discharge commenced from the middle ear, undoubtedly produced by the water pouring through the rent into the tympanic cavity, and

thence into the mouth through the Eustachian tube. The hearing power was very much reduced; a low conversation could be heard at a distance of a few feet, and the watch about three inches from the head.

The third case was so nearly like the one just reported, that it is not necessary to go into details.

In the last case that I observed the rupture of the membrane was caused by the physician's instrument, who, in his endeavor to remove an insect from the meatus, perforated the membrane. This was followed by acute suppuration of the middle ear.

The treatment of the first and third cases was practically to let them alone. Nature, unassisted, repaired the damage. In the second and last cases the treatment was that of an acute suppurative inflammation of the middle ear.

The prognosis in these cases, pure and simple, is good, the acuteness of hearing usually being restored in a very short time.

The case reported by the essayist to-night is not unique, inasmuch as there have been a number of such cases reported; nevertheless it is very interesting.

These cases may be divided into two classes—first, those in which the rupture is due to a sudden vibration of the atmosphere, as after explosions or the firing of heavy artillery; second, those which result from a blow or some injury to the head as a cause of rupture. To this latter class belongs the case of the essayist. These cases are of far greater importance to us, since they occur at any time. Dr. Weir, of New York, reports three or four cases where the rupture was due to a blow upon the head. In these cases, and those which have come under the speaker's observation, the drum membrane was supposed to have been in a diseased condition. It requires considerable force to rupture a membrane. Dr. Gruber has determined that it will support a column of mercury 150 cm. high, or that it cannot be ruptured by air condensed five-fold, which was allowed to press against the membrane suddenly, either through the external auditory meatus or the Eustachian tubes. In the majority of cases reported the rupture was posterior to the handle. As long as the case is one of simple rupture, recovery will take place in a few days; but in some of the cases where recovery of hearing seems tardy, it may be due to a disease which had existed, or it may be due to a fracture or dislocation of the vesiculi, or an injury to the labyrinth.

There is not another tissue in the body which will repair as rapidly as the drum membrane. A perforation may be demonstrated by Valsalva's or Politzer's method of inflation, if it cannot be seen.

With reference to the membrana tympani as an absolute necessity to acute hearing, that certainly is a fallacious idea, since many persons with perforations due to chronic suppurations have normal hearing. The membrane acts largely as a protection to the middle ear. Many sounds could be heard more acutely if we were to perforate the healthy membrane.

The speaker illustrated the reparative process of the membrana tympani by citing a few cases where stem-grafting was resorted to for the restoration of the membrane. The perforation healed in the course of three or four days.

EDITORIAL DEPARTMENT.

PERISCOPE.

A Case of Traumatic Tetanus Successfully Treated with Calabar Bean.

Dr. John Dougall thus writes in the *Glasgow Med. Jour.*, March, 1885:

As traumatic tetanus usually terminates fatally, the following case is interesting:

While acting vice Dr. Scott Orr, Jessie L., aged 16, farm servant, was admitted to Ward I on September 5, 1884. About twelve days previous to admission, while milking a cow which had sore teats, it became restive, and tramped on her right great toe, tearing off the nail and bruising it severely. After a few rude dressings it healed. About a week after the accident she felt her mouth "sore and stiff," i. e., lockjaw. After two days the stiffness extended to her neck, and in about three days to her back, which became so rigid and painful that she could only rest on the occiput and buttocks, her shoulders not even touching the bed. This condition lasted for two days, after which she was able to leave her bed, although still a little stiff and pained. On admission to the Infirmary she complained of a pain which darted at intervals from the medullary region to the sacrum when attempting to turn in bed; during the night the pain gradually subsided so that she was able to turn, although she still felt stiff. Next night she had little sleep from sudden attacks of pain, causing pleuristhotos and opisthotos. Never had convulsions; had not been exposed to damp or cold; family history good.

Physical Examination.—Back tonically arched; muscles rigid from neck to sacrum; no pain or pressure over cervical and lumbar vertebrae; sensation normal; plantar and patellar reflexes not exaggerated; arms and legs flaccid and painless; no headache; darting pains down back; tongue furred; no difficulty or pain in swallowing; appetite good; bowels regular; respiration, circulation, menstruation, urination, and temperature normal.

Treatment.—September 5—

R. Pot. bromidi, gr. xxx.
Fiat pulv.

Sig.—One every four hours.

September 6. Pain in back more severe; frequent marked opisthotos on attempting to turn in bed; rests almost constantly on right side, with thighs and knees much flexed.

September 7—

R. Liq. morph. hydroch., ʒss.
Sig.—m[℥]10 to be taken with the bromide powder.

September 8. No improvement. Bowels confined, probably from the morphia.

R. Pulv. scam. co., gr. vj.
Hydrarg. subchlor., gr. iv.
Fiat pulv.

Sig.—To be taken at once.

Powder acted freely; pain in back still severe; opisthotos frequent. As patient was not improving under the treatment, I resolved to try Calabar bean *per se*, as follows:

September 10—

R. Ext. physostig. fab., gr. ʒ.
Ext. gent., gr. iij.
Fiat pil.
Mitte tales, xxiv.

Sig.—One every hour.

September 12. Last night she had a severe attack of trismus and opisthotos, which lasted about ten seconds, her body resting on her head and heels. Hence the dose of Calabar bean was increased:

R. Ext. physostig. fab., gr. ʒ.
Ext. gent., gr. iij.
Fiat pil.
Mitte tales, xxiv.

Sig.—One every hour.

September 14. Feels much easier; attacks of spasm less frequent, less prolonged, less painful; no dysphagia. Sleeps well.

September 17. Tonic curvature of spine less marked; general condition improving. Dose of Calabar bean further increased, thus:

September 18—
R. Ext. physostig. fab., gr. ʒ.
Ext. gent., gr. iij.
Fiat pil.
Mitte tales, xxxvi.

Sig.—One every hour.

October 1. The improvement noted on September 17 has continued. Can now sit and stand, yet her back is still abnormally curved and rigid. During the past three days has only been getting ¼ grain of the ext. physostig. fab. every two hours, and during the day only—the medicine having previously been given both night and day, excepting when she was asleep.

October 11. Patient still improving; was up for a short time to-day. Back still a little rigid and arched. No trismus for at least two weeks past. Dose of medicine further increased thus—

R. Ext. physostig. fab., gr. ʒ.
Ext. gent., gr. iij.
Fiat pil.
Mitte tales, xxiv.

Sig.—One every two hours during the day.

October 17. Patient has been up the greater part of the day; has no complaint; can walk, run, stoop, and rise with perfect ease; spinal curvature gone. Medicine being gradually withdrawn.

October 20. Dismissed, well.

A Case of Pyrophobia.

Dr. William Penny translates from the *Revista Medico-Quirurgica* for the *Texas Courier-Record* of Medicine the following:

During the last month I was called to see a case in general practice that I deem worthy of

record from the singularity of the phenomena and the suddenness of the attack.

She was a girl thirteen years of age, of nervous temperament and delicate constitution, a native of the city of Buenos Ayres.

In consequence of the views that I entertain of the cure of certain classes of neuroses at their residences, I had no hesitation in taking charge of the case.

The family of the patient attributed her malady to various causes, and dated its commencement to a period about three months prior to my first visit.

To me, a hereditary predisposition appeared to be the principal cause of the malady. The mother had suffered from attacks of epilepsy in her youth. In addition, a sister, a child, was also an epileptic.

The patient had been seriously wounded as well as terribly frightened some years before, when she was bitten by a dog. The wounds, which were extensive, were very painful and required a long time to cicatrize.

When cured of the wounds from the bite of the dog she remained well until she received a second profound shock from a burn of the second degree. After that, her relations first observed her fear of the fire.

All precautions taken were converted into true terrors by her, and she fled like a bird from a conflagration. If her sensitive olfactories discovered a smoke, she attempted to escape. Even the smoking of a cigar in the house or on the grounds she frequented, disturbed her so that it was interdicted.

Her relatives thought, from the extreme rareness of the phenomena, that the attacks were simulated. Close observation convinced them that they were involuntary.

One evening, in passing a public square at a distance, she saw a bonfire. She was immediately seized with violent trembling and hallucination, crying that her body was surrounded with flames, and tearing off her clothing. This was the day of her first attack. As these attacks recurred she was clothed with boys' clothing. The precautions against heat were carried to the extent of allowing her to sleep in a bed entirely naked, except a linen sheet for covering. All this while the weather was very cold. She continued to do this for a number of days, to the great astonishment of her family at her powers of endurance of cold.

At my first visit, which was short, I confined myself to a simple observation of the patient and to obtaining the history given. The patient was in a state of complete nudity, covered only with a sheet. During the day she entered into the sports of her age, but remained in bed. When she changed her bed she suffered a little from cold, there being nothing to warm it but her body.

The nervous attacks were distinctly intermittent, occurring chiefly at night. Each of these came on with a sense of stinging pain over the whole body, and an intense desire to pass her urine.

I invited a number of my colleagues to see her with me. She was, at the time of their visit, taking quinine as an antiperiodic, as the attacks were rapidly debilitating her.

When it was found that the means taken to

quiet her nervous condition were insufficient, she was removed to the house of a relative.

After her removal from her home to the house of her relative, her appetite and digestion greatly improved and remained good. Her sleep was restless, and in the small hours of the night she would double herself up. If an attempt was made during her sleep to add other covering than the sheet, she would quickly recognize it and throw it off. In the majority of attacks she would have hallucinations of vision and illusions of mind. There was no fever during these attacks. The pulse was regular, but feeble; the temperature normal. In the intervals her speech was distinct and her mind clear. She was able to relate her sufferings at the periods of her greatest anguish. We convinced ourselves of the correctness of her answers by experiments.

Treatment by general tonics and horseback exercise. Recovery in a few weeks, when she resumed the dress of her sex.

Quinine and Typhoid Fever.

Dr. O. T. Schultze thus concludes a paper in the *American Practitioner* for November:

"The question to the solution of which I have now attempted to contribute my mite, I take to be, not whether quinia properly administered in typhoid fever lessens the severity of this disease, its duration, and its mortality, for this point I regard as settled beyond peradventure or doubt; but whether this effect of quinia is due merely to the antipyretic property it possesses in common with cold water, or whether there is some other virtue in quinia that causes its good results in typhoid fever. And if the advantages derived from the employment of quinia in typhoid fever are not due to its antipyretic but to some other property, whether some mode of administering this drug should not be adopted by which, while antipyrexia is incidentally accomplished and hyperpyrexia prevented, this other virtue, call it specific, depurative, or what not, may be brought most fully to bear on the typhoid fever process. I think that I have shown that if a dose of quinia, large but proportioned to the age of the patient, is exhibited every other evening, or if the disease is very obstinate every evening, throughout the entire course of the pyrexia, typhoid fever is reduced to a very manageable and little dangerous affection, and its course greatly curtailed. It matters not whether we call this action of quinia a specific action, or whether we concur with Binz, who asserts that, 'Quinia does not put an end to an attack of typhoid fever as it does to one of intermittent fever. In the first-named disease it has no specific operation, but only so weakens the putrid ferments that they run their course less destructively.' For, in reality, we know as little of the action of quinia in the one as we do in the other of these fevers, and we simply call the action of quinia in malarial fevers *specific* because we see that certain easily recognizable phenomena always follow its use in these fevers. Phenomena of the same nature, only less in degree, also follow its administration in typhoid fever; for, according to Ringer, even in ague quinia frequently removes only the grosser manifestations of the disease, and hence is not by far the ideal specific

it is usually thought to be. He says (Therapeutics, 1880, page 579):

"Quinia generally arrests the disease (intermittent fever) at once. It is well, however, to bear in mind that this remedy may dissociate the other symptoms from the elevation of the temperature; or, in other words, it may remove the shivering, sweating, quick pulse, while the temperature may remain as great, or nearly as great as on previous days. Mere rest will occasionally effect the same dissociation. Unless the unnatural elevation of temperature has been restrained, the paroxysms will speedily return. This fact it is necessary to recollect, otherwise it may be concluded that with the removal of the more obvious symptoms the disease itself is cured, and thus the patient may be permitted to return to his usual avocation.

"A still more curious circumstance remains; that is, quinia may check all the symptoms, even the periodical elevation of the temperature, and yet, about the same time of day that the series of symptoms were wont to take place, an increase in the urea and urinary water may occur as during a severe paroxysm; that is, all the symptoms of the paroxysm are absent, except those pertaining to the urine."

"But to the action of quinia in the typhoid fever process of what kind soever, the experience detailed above appears to me to show conclusively that quinia possesses a property which so subdues, moderates, mildens, and shortens this process that the disease runs its course without producing its usual ravages on those organs on which it is wont to spend its force, and that this peculiar property or power is not identical with that by which it reduces a high temperature to one of low degree."

Injury of the Eye by an Arrow.

Dr. C. W. Tangeman reports the following case in the *Cinn. Med. and Dental Journal* for November, to show how much mutilation an eye can undergo sometimes without causing its complete destruction:

Edward B., æt. 12, a healthy child, called at my office, in company with his parent, for the treatment of an injury that he had received to the eye by an arrow from the bow of his playmate.

Upon examination I found little or no injury of the eyelids, for the projectile had been received at short range and unexpectedly, thereby entering the palpebral aperture before the lid could be closed to protect the eyeball. The point of the arrow had penetrated the cornea, making an irregular triangular opening with one of the corners pointing upward into the pupillary area, of sufficient size to admit the end of an ordinary lead pencil. The lower half of the iris was lacerated so as to protrude from the wound in the cornea. The suspensory ligaments were ruptured and the lens was dislocated. The eyeball was quite soft on account of the escape of the aqueous humor. In consequence of all this disturbance, vision was lowered so that patient could only distinguish the difference between light and dark, in the injured eye. After an attempt at replacing the torn iris, the eye was carefully washed with a saturated solu-

tion of boracic acid, and a few drops of a four-grain solution of eserine was instilled. The eye was now carefully dressed by a compress bandage, and the patient sent home.

On the following day the dressing was removed; the margins of the corneal wound had adjusted themselves so nicely under the compress that the anterior chamber was already beginning to refill. The patient had suffered little or no pain, and the treatment of the first day was repeated. The symptoms of inflammation of the iris were so slight that the use of eserine was at no time discontinued. The rapid refilling of the anterior chamber and healing of the corneal wound prevented anterior synechia.

In this case, on first presentation, the question was more to preserve the eyeball for cosmetic effect than to preserve vision. Though at the present writing, which is fully six months since, the corneal wound has left only a trace of opacity along the line of rupture, but the shape and size of the pupil has been disturbed on account of laceration of the iris. The lens has become quite opaque, so that the individual can only distinguish the difference between light and dark. The peculiarity of this case was that the process of repair was so speedy and accompanied by so little reaction, that the patient never uttered the slightest complaint of pain. The corneal wound healed almost as readily as though it had been a clean cut made by the knife. The patient was not confined to the house or a dark room, but presented himself regularly at the office for treatment. The only treatment that the patient received was instillations of eserine once daily and thorough cleansing of the eye by boracic acid solutions. An operation for the removal of the nucleus of the lens, accompanied by an artificial pupil, will undoubtedly restore the normal acuity of vision; making allowance for the loss of the lens.

A Case of Spontaneous Delivery of Brow Presentation.

Dr. George Minges, of Dubuque, Iowa, reports this case in the *Am. Jour. of Obst.* for November:

March 20, 1884, I was called to see Mrs. H., living only two or three squares from my office, the messenger stating that the midwife had sent for me, on account of faulty presentation. On entering the room, I found the woman in strong pains and clamoring for assistance, so immediately I examined her without preliminary questioning. On entering the vulva, my finger at once touched a soft mass feeling like a buttock. The competent and intelligent midwife thought the presenting part to be the breech, and stated that it had not moved for three hours, until, during the husband's short absence at my office, good pains arose and rapidly pushed it to the inferior strait. Although, in my hasty examination, I could not feel the anus, the rapid descent of the part left me no time for deliberation, and accepting the diagnosis, I had the patient across the bed, so that I could the better assist the after-coming head, in case it should become arrested. Meanwhile the presenting part had appeared at the vulva, but great was my surprise on noticing the hairy scalp, as the prolonged and compressed vertex swept forward over the perineum, and still greater on, immediately after, watching the

face roll out beneath the symphysis. All this happened so rapidly that I was quite puzzled, until I noticed the immense caput succedaneum over the right brow, which was so thick that no bone could be felt through it, and thus had misled both the midwife and myself into making a diagnosis of breech presentation. The child was cyanotic and, after some attempts at resuscitation, gasped a few times, stretched itself, and appeared to be dead, to the relief of the mother, who feared that it might have remained a cripple, so great was the cranial deformity. After the mother had been made comfortable, my attention was attracted by a rattling sound emanating from the bundle of rags in which the dead infant had been wrapped, and examination of the latter showed that its heart was beating slowly, and that at long intervals it was making gasping respiratory efforts. After sucking the mucus out of the trachea through a catheter, I tried both Sylvester's and Schultze's methods of artificial respiration, but in spite of these, both breathing and pulse became more feeble, until I found alternate streams of hot and cold water forcibly syringed against the epigastrium, to be the best respiratory stimulant, and after more than an hour's hard work, I finally had the satisfaction of hearing the child cry. In spite of an attack of eclampsia during the following night, the child thrived, until it died of enterocolitis, at the age of about three months; but some hyper-extension of the head, I believe, remained up to the time of death. The mother, a healthy German multipara, who made an uninterrupted recovery, although of short stature, had a very wide pelvis, and this probably accounts for the ease with which she gave birth to a child of average size in what has generally been considered one of the most unfavorable presentations.

A Case of Multiple Abscess of Liver.

Dr. Frank Cary, reports this case in the *Chicago Med. Jour.*, October:

Matthew F., a medium-sized Irishman, of temperate habits, fifty-five years old, a stone-cutter by trade, was admitted to St. Luk's Free Hospital, September 1, 1884, with a diagnosis of typhoid fever.

He gave a history of perfect health up to within three weeks of his admission to the hospital; when he began to suffer from headache, anorexia, profuse diarrhoea, and general malaise. There were no chills. The diagnosis of typhoid fever was questioned.

On admission, no tenderness could be detected in the region of the liver, or elsewhere over the abdomen. The patient, although very much exhausted, was not markedly emaciated. The stools were similar in appearance to those in typhoid fever of the third week. On the first day the temperature was normal. On the second day, by 6 p. m., it rose to 103°. On the third day it was normal in the morning, but gradually rose until 10 p. m., when the patient died, apparently from exhaustion.

The autopsy, twelve hours later, revealed the following conditions: The liver was completely riddled with abscesses, there being no less than twenty-four, varying in size from a hickory nut

to a goose egg, and filled with dark, brownish pus, having no appreciable odor. The lobulus Spigelii was almost entirely destroyed by a large abscess. The organ, as a whole, was nearly normal in size; it was adherent to the diaphragm, the anterior abdominal wall, and to the transverse colon. There were different abscesses pointing in these several localities; of them, only one, that attached to the diaphragm and in the right lobe, seemed ready to rupture.

The colon, from the ileo-cæcal valve to the sigmoid flexure, was lined with ulcers. These coalesced so as nearly to obliterate the mucous membrane within these limits. The remaining intestinal tract was normal. The spleen was neither enlarged nor softened, as it was in a somewhat similar case reported by Dr. Peabody, of New York. The gall-bladder was normal, and contained the normal amount of bile. It should be stated that this patient had for years been a resident of Chicago, and had never lived in the tropics.

Are we not justified in believing that these intestinal ulcers and the abscesses of the liver stand in the relation of cause and effect? Coats, in his Pathology (page 587), in discussing the point, says he thinks this view is not, however, beyond question.

Relation of Hygiene to Practical Dentistry.

Dr. C. E. H. Phillips thus writes in the *Independent Practitioner* for November:

The great advance made in recent years in treating diseases of the mouth is certainly encouraging, and though excellent results are by no means uncommon, we should not rest here. Patients must be so instructed as to aid us in our endeavors, and not until they are impressed with the importance of the hygienic care of the mouth is our duty fully performed. The unwarrantable neglect of many patients in this regard is astonishing.

The physician, who by careful treatment and strict enforcement of sanitary laws has stamped out from a family or community the scourge of malignant fever, with precautionary instructions as to ventilation, diet, and hygiene, for the protection of its other members, would at least feel discouraged, and justly so, should a recurrence of the disease result from gross neglect of sanitary conditions, or carelessness as to instructions given.

How very often is the dental practitioner subjected to like discouragement. Having corrected diseased conditions in the oral cavity, carefully cut out all carious dentine and nicely filled the cavities, removed accumulated calculous and mucous stains from the teeth and polished their surfaces, resulting not only in a pleasing appearance, but to the operator in the consciousness of having performed saving work and aided the general health, and after faithful instruction as to thorough and careful use of the brush, with a good dentifrice, at proper periods, the employment of waxed floss silk and quill tooth-pick, is it to be wondered at if a feeling very akin to disgust is experienced, if in a few months or a year the patient again presents himself with tartar already forming in quantities, the teeth yellow from mucous attachment, the gums soft and spongy.

ready to ooze blood from their gingival edges upon the slightest touch, all evidencing little care or use of the brush, or, possibly, its total disuse and general disregard of common hygienic requirements?

There is no question that the great essential to a healthy mouth, wholesome saliva, and pure breath, is *cleanliness*. Not until the dentist is able to force upon his patients the necessity of *thorough* cleanliness of the mouth at all times, and has their assistance to this end, shall we save teeth and keep the surrounding tissues in a state of health, and not until then should we rest satisfied.

Arrested Fetal Development.

Dr. C. A. Danforth thus writes in the *Texas Courier-Record of Medicine*:

On the night of the 18th of August, 1885, I was called to see Mrs. B., living near Granger. On my arrival, I found her in labor, and by vaginal examination ascertained that the os was well dilated. The membrane was still unbroken, which I ruptured, though I was unable to make out the presentation. After the escape of the liquor amnii, I detected what I supposed was a breech presentation; but on sweeping my finger around the presenting part I discovered on either side an ear, and by pressing my finger well up around the presenting part I could trace a ring of bone completely encircling it.

The presenting part advanced and receded with each pain, so I did not feel easy as to the termination of labor, and in due time the child was born. It proved to be a male child, well developed in every part except the head. All the upper part of the cranium was missing from a line corresponding with the following points: just above the eyebrows, to the top of the ears and just above the attachment of the ligamentum nuchæ. The bones and scalp from the ears, backward ended abruptly as if cut by a knife, while from the ears forward the bones came to a beveled edge. The dura mater did not extend beyond the edge of the bones, so the lobes of the cerebrum were uncovered except by the visceral layer of the arachnoid. The two hemispheres of the brain thus constituting the presenting part and the point of my index finger passing between the lobes, caused me to mistake the head for the breech on my first examination.

The lady, who I forgot to state was a primipara, told me by way of explanation of the cause of the defect, that in the early part of her pregnancy some dogs had bayed a hog in the yard, and that the top of the hog's head was torn off by the dogs, leaving a raw, bleeding surface, which bloody sight made so strong an impression upon her mind that she could not help thinking about it for a long time.

I would like to ask the question, will maternal impressions cause such terrible results? This child was well developed in every other part except the top of the head. The cerebrum was not developed in proportion to the rest of the body. It lived a few hours, getting its breath by gasps at long intervals.

Removal of the Entire Tibia.

Dr. B. F. Hart, of Marietta, Ohio, thus writes in the *Jour. Amer. Med. Association*, November 7, 1885:

In December, 1883, I was called to see a boy, aged thirteen years, who had been treated three weeks for rheumatism. On examination, I found the leg much swollen, very hot and painful, with marked fluctuation, the result of extensive periostitis. The boy was very anæmic, and much exhausted.

I opened the leg at its upper third, and anterior aspect, and discharged over a quart of pus and broken down tissue. A rubber band was applied, and a restorative course of treatment was given for four weeks, until the system could be restored sufficiently to permit the removal of the diseased bone. On January 30, 1884, with the patient under influence of chloroform, I began an incision close to the knee, and finding no sound bone, continued the same to the ankle; and by the use of the enucleator, separated the tibia from its epiphysis.

The upper end having been loosened by disease, the entire bone was easily removed. With the raspatory I scraped the tibial side of the epiphysis at the knee. After dressing the wound with oakum for ten days, it was gradually drawn together by means of adhesive straps. In ten weeks the new bone had so far reformed that he could bear his weight upon the limb. About four months elapsed before he was able to walk without the aid of crutches. At this date (October, 1885,) recovery is perfect, tibia full size, and there is no halting in his walk.

REVIEWS AND BOOK NOTICES.

NOTES ON CURRENT MEDICAL LITERATURE.

—In a reprint before us, Dr. D. B. Delavan, of New York city, draws attention to the frequency of erysipelas of the pharynx and larynx, and speaks of the importance of an early diagnosis and active treatment.

—Disease of the ear is rarely fatal, but one such case is recorded in a reprinted article by Dr. C. J. Kipp, of Newark, N. J. It began as a circumscribed inflammation in the outer half of the external auditory canal, and developed a mastoiditis, with fatal termination.

—The New Orleans *Picayune* of recent date contains a letter from J. McF. Gaston, of Atlanta, calling the attention of the health authorities to the method of inoculating for yellow fever as proposed by the Brazilian physician, Dr. Domingos Freire.

—Professor Burt G. Wilder, of Cornell University, is one of the most active students of the anatomy of the nervous system and allied branches, whom we can name in this country. A

number of short papers on our table testify to his constant energy in these investigations. They refer to the methods of preparing and preserving specimens, to little-known fissures and arteries of the brain, to "paronymy and heteronymy as neuronymic principles," and to other topics of interest to neurologists.

—The second edition of the *Manuel des Injections Sous-cutanées*, written by Drs. Bournéville and Bricon, and published by De la Haye & Cie., Paris, has reached us. It is a carefully-prepared little hand-book on this subject.

—Dr. A. Martin, of Berlin, sends us a reprint of his article on the castration of women, as contributed to the *Real-Encyclopedie der Gesammten Heilkunde*, now in process of publication in Berlin. Dr. Martin gives an admirable summary of the topic, and a list of the most valuable monographs and articles upon it.

—The *Kansas City Review*, now under the editorial charge of Dr. Warren Watson, has greatly improved both in appearance and contents. It has many valuable original articles on subjects of science, and its miscellaneous and editorial pages reveal sound judgment and good taste in those who have them in charge. There is room for such a periodical, and the *Kansas City Review* promises to fill it well.

—One of the ablest papers in practical psychology that we have read for a long time is by Mr. Benjamin Smith Lyman, in the last number of the *Journal of Speculative Philosophy*, and separately reprinted. The subject is "The Character of the Japanese," and the acuteness and evident justice with which the author analyzes the psychological traits of this interesting people, are instructive and admirable.

BOOK NOTICES.

A System of Obstetric Medicine and Surgery, Theoretical and Clinical. By Robert Barnes, M. D., etc., and Faucourt Barnes, M. D., etc. Sheep, 8vo., pp. 884. Illustrated. Philadelphia: Lea Brothers & Co., 1885.

As is justly observed in the preface to this work, it is no light undertaking nowadays to write a systematic and complete treatise on any branch of medicine, especially one which involves such various studies as the obstetrical specialty. Few, however, are better qualified for the task than the distinguished London physicians, father and son, whose names appear on the volume above named. They bring to the task a thorough ac-

quaintance with the literature of the subject, supported by a range of observation of extraordinary extent both in hospital and private practice.

The subjects treated include the whole field of obstetrical science. Beginning with a detailed description of the anatomy of the female generative organs, the reader is instructed in the phenomena of generation and conception, the life of the embryo, the processes of gestation, childbed and lactation, the diseases attendant upon them, and those to which the embryo is liable, including a most instructive chapter on abortion, labor and its complications, the accidents of childbed, the various manipulations and surgical operations which it may demand, and the treatment of the neonatus.

Numerous illustrations elucidate the text, and the clear directions of the authors render the volume a most satisfying one.

A Treatise on Nervous Diseases, Their Symptoms and Treatment. By Samuel G. Webber, M. D., etc. Cloth, 8vo., pp. 415. D. Appleton & Co. New York, 1885.

The author states that he has not written this volume for specialists in the branch to which it refers, but for students and general practitioners. He has aimed to exclude the discussion of uncertain points of physiology and the recondite discussions of pathological questions which consume so much space in many works on diseases of the nerves, and to confine his remarks to those ascertained facts which will guide the reader most directly to the correct diagnosis and treatment of the cases he may meet.

The earlier chapters explain the anatomy and physiology of the nervous system; from this the author proceeds to diseases of the membranes of the brain, cerebral hemorrhage, occlusion of the cerebral arteries, tumors and abscess of the brain. He then turns to diseases of the spinal cord, followed by diseases of the peripheral and sympathetic nerves, and concludes with a number of unclassified diseases, such as vertigo, chorea, epilepsy, hysteria, neurasthenia, etc. The author's style is clear and unpretentious, and his work will be found a very convenient one for the general practitioner who would acquaint himself with the outlines of the modern aspects of neurology.

—In the *Russkaja Meditzina*, 1884, No. 45, p. 932, Dr. Kurkovsky, of Tula, relates a case of dysentery treated and cured (apparently) by the internal administration of naphthalin. The drug was given every other day in single ten-grain doses, in combination with half an ounce of castor-oil.

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PREVENTION OF CONSUMPTION.

In spite of the fact that consumption of the lungs annually kills more persons than all other diseases put together, physicians are to-day, practically, as unable to cope with it as they were a hundred years ago. The very best doctor can tell you when you have consumption, and can give you remedies that will "tone you up," and maybe allow you to live a little longer, but he cannot cure the disease. In the very great majority of cases, when the disease is once established it is only a matter of time, the disease running a faster course in some than in others, but in nearly all running steadily on to the graveyard. A few, a very few cases are cured, but so few as to be hardly worth noting.

But we can, in the majority of cases, prevent the disease. Look about among your friends, and you will rarely see one with a full, broad, well-developed chest suffering from consumption; this disease finds its victims among those who have narrow, flat, sunken chests, who are round shouldered, and in whom a line stretched across the chest from shoulder to shoulder would be found concave instead of convex, as it should be. Breathing bad air is a most common cause of the disease, and if any of our friends, whose children attend certain of the public schools that we have had occasion recently to visit, read this article, they will learn that the seeds of the disease are being now planted in their children's lungs. We have seen some of these buildings where, in a room thirty feet square and twelve feet high, one hundred children are confined for several hours daily. This allows only 108 cubic feet of air-space for each child, when it ought to be at least from five to ten times as great.

The ventilation is also very faulty in these rooms, and the children are continually breathing and rebreathing this bad air, that is sure to cause sickness, and very likely to give them consumption in after life.

The remedy for this condition is obvious; you pay taxes for schools for your children, and you must insist that proper accommodations shall be afforded. While, for instance, the miners in our

coal regions are working hundreds of feet beneath the ground, they are breathing pure air that their employers furnish them at great cost, because they know that they can do more work when they breathe pure air; but their children are at the same time breathing a very foul atmosphere. You should have school-rooms for your children where each child will have at least 500 cubic feet of air-space. A room thirty feet square and twelve feet high should not contain more than twenty children.

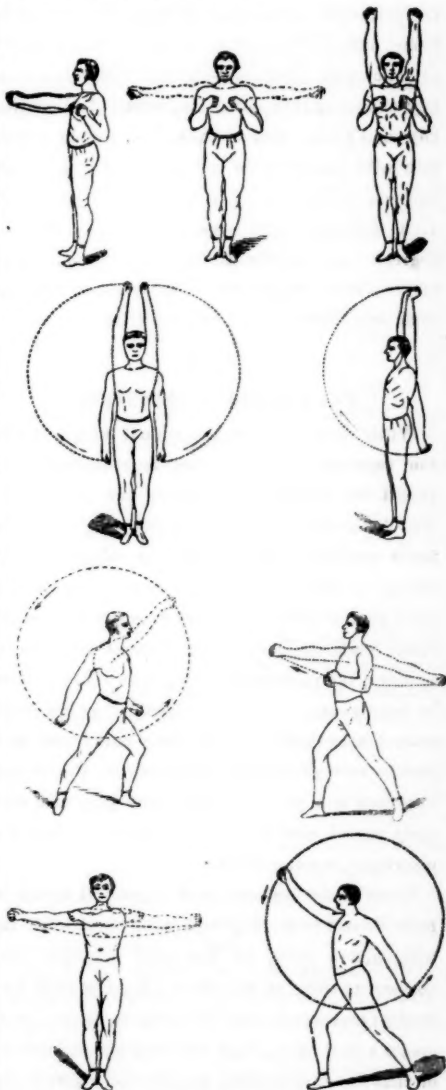
When you have accomplished this point, you have taken the first step in the prevention of consumption, and you can accomplish it if you desire, for if you let your authorities know that you want sufficient accommodation and are willing to pay for it, they will give it to you. The majority of persons in this world want to do the right thing, if they are told how to do it.

When you have secured pure air and plenty of it, the next step is to cultivate habits of exercise that will tend to develop, to expand the chest. In rural and suburban districts children will derive enough exercise for the muscles of the legs in walking to and from school; but, sitting for hours bending over a desk, they become round shouldered and get no exercise for the muscles of the upper part of the body. To overcome this certain habits should be encouraged. In the first place the lungs should be fully expanded by drawing in all the air that is possible; this process will be aided by throwing the shoulders well back, and you should encourage your children to do this frequently in the open air when going to and coming from school. Children are easily bribed, and we would suggest to school teachers a simple and effective way of accomplishing this desirable end. This forcible expansion of the lungs will enlarge the chest and increase its circumference. Then let the teacher, at the beginning of the session, measure each child's chest and record the circumference, then explain and demonstrate to them how to forcibly fill the lungs, and offer a premium at the end of the session to the child who shall have most increased the circumference of his chest; make it worth their

while to expand their lungs, as much so as we now do for them to expand their minds, and the result will be wonderful.

We will be glad to publish the results of such experiments, as they will prove most valuable.

Then comes exercise of the various muscles about the chest and arms; which is illustrated in the accompanying diagrams:



Take advantage of the boy's or girl's ambition; see how many times they can perform these var-

ious movements; let them commence with say ten of each, and together in class go through them daily for one week; then increase to fifteen times, and so on, adding five each week, and at the close of the session have a public exhibition, inviting the parents and friends, and awarding a prize to the child who can perform these movements the greatest number of times. The desire to secure the prize will induce the children to exercise at home, and parents will be surprised and gratified to notice their puny, flat-chested children gradually changing into muscular, robust, full-chested boys and girls. Follow these few simple recommendations, give pure air and proper exercise, and you can feel sure that very few of your children will ever have consumption, and that by degrees this terrible disease will become eradicated. These suggestions to school teachers would come *very appropriately* from physicians.

THE HYGIENE OF PREGNANCY.

While it is a law of the animal kingdom and the vegetable as well, that reproduction at a period too early, that is before the parents are well developed, will result in offspring of an inferior quality both of body and mind; yet Dr. Busey, of Washington, very truly tells us that proof of this fact is repeatedly found in the human race. Unfortunately, at the present day, in this country, the passions and impulses are cultivated by indulgences; "young America" grows faster than his ancestors did in every point, and as a part of this precocious development, the sexual functions and passions come into play at a very early period, and early desires, gratified by early marriages, are the result.

These immature men and women (it would be more correct to say *boys and girls*) require all the constructive force, all the vital principle they possess, to complete the development of their own bodies; and when they part with some of this to create a new being, they not only rob themselves of that which is needful, but they only give to the new formation an imperfect force, which is usually incapable of forming a perfect creature.

To say nothing of the moral aspect of early marriages, which is a grave point, because it is a notorious fact that the majority of very early marriages turn out unhappily, owing to the fact that the contracting parties are too young to have the sense to realize what they are doing, and soon tire of the self-denials that even the happiest married life demands—to say nothing of this, we must admit that very early marriages have a strong tendency to produce inferior offspring, to deteriorate the physical power of our people, and thus to materially interfere with our productive power as a nation. This question deserves grave consideration, for early marriages are becoming very prevalent in this country. We would say, as a general rule, for the guidance of the people, that the man should be about twenty-five and the woman twenty years of age.

Other things being equal, the nearer we conform to this rule, the stronger will our children be, and the happier will be our married lives.

DAMP CELLARS.

The importance of having dry cellars cannot be too strongly urged upon the people. We recently visited an afflicted family at Phoenix Park (near Pottsville, Pa.,) where five members of the family were sick with typhoid fever and two had died, making seven cases in all. We made a very thorough examination of the surroundings of this house, had the drinking-water analyzed, and were forced, by exclusion, to the conclusion that the sickness in this case was caused by a damp cellar.

A stream from a worked-out mine keeps the locality marshy and the cellar wet. To obviate this, a drain had been run from the cellar to a neighboring creek. This drain had become stopped, and some inches of water accumulated in the cellar. Had this family known that dynamite was in the cellar, they would not have slept easily until it was removed; but with this insidious foe to life and health they ate and slept contentedly until the favorite child, a boy of eleven, was taken ill and died. Then, suspecting the

damp cellar, the drain was cleaned out; but it was too late; the mischief was done, the family was infected, and all of the children had typhoid fever. As I looked at the bereaved and saddened mother I could but pity her want of knowledge, that had brought such terrible affliction. *The doctor could not cure, but the parents could have prevented.* Do not live over a damp cellar for one hour.

NOTES AND COMMENTS.

The Treatment of Expulsive Gingivitis and Osteoperiostitis.

The *N. Y. Med. Jour.*, November 14, says:

The frequency with which physicians practicing in small communities, where the services of a dentist are not always to be had, are called upon to treat recession of the gums, and the accompanying osteo-periostitis, has led a French journal styled *L'Odontalgie* (quoted in the *Gaz. Hebdom. de Méd. et de Chir.*) to summarize the treatment recommended by Dr. Mailhol, of the Argentine Republic. That gentleman employs treatment preparatory to medication with iodine, after having freed the teeth from tartar, especially by means of a collutory made after the following formula:

Boric acid in fine powder 75 grains.
Saturated chloroform-water 3 ounces.
Dissolve the boric acid, and add:
Distilled anise-water 3 ounces.
Distilled water 6 ounces.
Shake and filter.

For the treatment of alveolo-dental osteo-periostitis, the author formerly used chromic acid, as advised by M. Magitot, but now he agrees with Dr. Harlan (*Dental Cosmos*) in preferring iodide of zinc. The cavities are first washed out with the collutory, by means of a syringe, and then filled with cotton medicated with chloral, glycerin, and a solution of iodoform, in its own weight of chloroform. The pain having been allayed, and the swelling having disappeared, the affected alveolar border is removed, and an injection is thrown into the cavity of a few drops of a solution of iodide of zinc in distilled water (1 to 40 at first, gradually increased in strength to 3 to 40).

Serious Accidents During Coitus.

As similar accidents are liable to happen at any time to any one, we note that Dr. Zeiss, of Erfurt, mentions, in the *Gynækolog. Centralblatt*, two in-

stances which have come under his notice of serious accidents occurring during coitus. The first was that of a newly-married young woman, who, after the first connection, suffered from such serious hemorrhage that, as cold sponging and washing did not arrest it, Dr. Zeiss was called in on the following afternoon. He found the patient faint, almost pulseless, and covered all over with a cold sweat. A quantity of blood and clots had to be removed before he could make an examination. He then saw two lacerations in the hymen, and from the deeper of these, a vessel, out of the ruptured end of which a continuous stream of blood was flowing. Digital compression against the bone not proving efficacious, he put in a stitch, which was left in for three days. The patient slowly recovered her strength under tonics. Neither she nor any of her family had the hemorrhagic diathesis. The other case was that of a married woman, aged 25, who had been delivered with forceps, but had done well and begun to attend to her household duties on the ninth day. At this time coitus took place, apparently in the genu-pectoral position. The woman suddenly felt a sharp pain, and a considerable quantity of blood flowed from the vulva. Medical assistance was obtained, and cold disinfecting injections used, which arrested the hemorrhage. When Dr. Zeiss saw her, he found a rent an inch and a half long on the right side of the upper part of the vagina, with jagged and gaping edges. This was treated successfully with iodoform powder, and the vagina plugged with iodoform gauze.

Catalepsy Cured by Perineorraphy.

Subinvolution, endometrium studded with fungosities, a lacerated perineum, and a recto-vaginal septum, covered with a firm, thick, cicatricial membrane, the slightest touch upon which elicited great pain, were the physical conditions observed in a case that Dr. W. D. Haggard reports in the *Southern Practitioner* for October. The woman was subject to well-marked attacks of catalepsy. Dr. H. removed, as completely as possible, all the firm, glazed, cicatricial tissue covering the recto-vaginal septum, as far up on either side as he thought would be required, when the parts were brought into their normal position by sutures, to restore a perineal abutment, which would subserve, as nearly as possible, the uses of the perineal body, destroyed by rupture and atrophy of the parts.

Having vivified the parts, he introduced four sutures of silver wire, approximating the parts by twisting the wires and passing them through a

rubber tube; the knees were held together for ten days, and the bowels kept from moving by opiates, when the sutures were removed and union by first intention found to be perfect throughout. His patient never had a cataleptic seizure afterwards.

The patient was then placed upon the following:

R. Bromide potash,
Fluid ex. ergot,
Syrup lemon,

℞j.
℞ij.
℞vj. M.

Dose.—One dessertspoonful three times a day, to overcome the flaccid condition of the uterus.

He also gave 100 comp. tonic phospt. pills: dose, one pill three times a day, as a general tonic alternative.

Transfixion of the Scrotum.

Dr. Alexander Ferguson reports this rather singular accident in the *Brit. Med. Jour.*, October 10, 1885:

He was called to see J. C., a farm-steward. He had finished the building of a corn-stack, against which had been stupidly placed a pitchfork, with the wooden handle uppermost. The shaft, which was of ash, and measuring about one inch and a quarter in diameter, entered his scrotum close to the perineum, passed upwards, and emerged on the dorsal surface, close to the penis, extruding the right testicle partially, and the left completely. No help being at hand, the poor man pluckily seized the scrotum in his left hand, and with his right withdrew the fork-handle, which had transfixed him to the extent of two and a half feet. This operation, he says, was attended with much pain. He thereafter walked home, a distance of thirty or forty yards, supporting his injured scrotum and displaced testicles.

About an hour elapsed before he saw him, and he was much struck with the disparity between the injury and the constitutional effects; the only complaint was slight nausea. He washed the testicles in a weak boracic lotion, and then restored them to their normal sites. He stitched up both wounds in the scrotum with carbolized silk, and applied a compress of boracic lint squeezed out of hot water, which was the only dressing. Strange to say, no rise in pulse or temperature took place.

The Causes of Hepatic Abscess.

Surgeon-General Moore combats the prevalent idea that gluttony and intemperance are the chief causes of hepatic abscess, in the *Lancet*, October 31. He believes that liver inflammations and abscesses are usually simply the immediate result of atmos-

pheric vicissitudes, nowhere so powerfully felt as in India, where on the coast the diurnal sea breezes succeed to a hot, moist, stagnant atmosphere, causing a sudden and considerable fall of temperature daily; where throughout the country during nearly the whole year the night temperature, or rather the early morning temperature, is so much less than that of the day; where the seasons are so different that they are ordinarily spoken of as the hot and the cold weather; where during the former period the lightest of clothing is irksome, while in many parts during the later period the thickest European clothing is acceptable; where the cutaneous surface of the Europeans especially is rendered extraordinarily susceptible to a lowering of temperature by the over-excitation and consequent cutaneous debility produced by heat; and where Europeans and natives, who neither eat nor drink too much, expose themselves habitually in the most utterly careless manner, after spasmodic exertion, to that fertile source of most diseases, and especially of liver disease, chill; impelled to such exposure by temporary gratification, and daily incurring fresh dangers under the confidence of a too frequently short-lived impunity. Chill induces in the robust, as a first step, a congestive or inflammatory condition, and in the anæmic probably hepatic embolism, the result being abscess.

Herpes Tonsurans and Favus.

In some stages it is very difficult to distinguish between herpes tonsurans and favus. Dr. G. Behrend, in Berlin (*Centralbl. f. Chir.*, 32, 1885), has recently discovered a method which enables a tyro at once to recognize which of the two diseases is before him. Behrend employed the reaction, observed by him and by Duckworth, which chloroform produces on hair attacked by trichophyton, the fungus causing herpes tonsurans. Whenever such hair is moistened with chloroform it shows after the evaporation of the drug, which occurs within from two to three minutes, a perfectly white color, while normal hair experiences under its influence no alteration of color whatever. This change of color in the diseased hair proceeds only so far as the fungus has penetrated. The cause of this color-change is to be looked for in the splitting of the hair and in the entrance of air through the clefts in consequence of this splitting. Though the hair is also split in favus, this never happens to such a high degree, and the chloroform reaction has no influence at all on favus. The same remedy cannot be used to determine the beginning of a cure, as the change of

color cannot be so easily observed while the hair is *in situ*, on account of the clear skin; but if a few hairs are retracted and then subjected to the action of the volatile drug, the same alteration of color will at once be observed, if the fungus is still present, while no such change will occur if the trichophyton has been destroyed—a sure indication of the beginning cure, as after the disappearance of the fungus the hair rapidly resumes its normal growth and color.

Aspiration of the Aorta.

To Dr. John B. Roberts, of Philadelphia, we believe, belongs a very prominent position in connection with the recommendation to puncture the heart itself in cases of extreme pulmonary congestion. However, we find very few men who are so fearless as to thus encroach with the knife upon the very citadel of life, and it is well that it is so. Were this procedure common, we doubt not that very many more unintentional homicides would decorate our death-lists than the majority of physicians would like. But that such an heroic procedure is sometimes called for, and may be the only resource between the patient and death, we can readily believe. Such a case (though the patient died after all) is recorded in the *Bristol Medico-Chirurgical Jour.* for September, 1885, by Dr. J. Dacre. In this case most intense pulmonary congestion suddenly set in. The man was pulseless. It was intended to puncture the right auricle, and a needle and cannula was inserted in the fourth intercostal space in the right side. The operation was repeated twice, and altogether forty-six ounces of blood was withdrawn, with marked and immediate relief each time. However, as we have said, the man died, when the lungs were found almost solid with edema. It was also found that the needle had pierced the anterior surface of the aorta.

Cocaine in Hydrocele.

Dr. G. A. Atkinson says in the *Lancet*, October 31:

"After withdrawal of the fluid from the hydrocele sac, it is easy to inject therein a drachm, more or less, of a five per cent. solution of the salt named, allow it to flow over the interior, and after five to ten minutes inject the selected iodine preparation, which will not give rise to any pain until an hour or more has elapsed, which pain, usually not severe, if necessary can be controlled by the exhibition of a morphia suppository, or by some similar means. The use of the cocaine salt in this manner further allows kneading of the

sac after the iodine injection, which kneading Davy and others have strongly insisted on; and while, on the one hand, paralysis of the sensory nerves of the serous membrane can, as Cohnheim showed, have practically no retarding influence on the development of the inflammation, on the other, no evil effects can follow the absorption of a quantity of cocaine so far below a toxic dose. To the extent of my limited experience, cases thus treated progress, with the exception of the pain, precisely as those in which no cocaine is employed."

Intestinal Obstruction.

There seems to be great diversity of opinion in regard to the question of the treatment of intestinal obstruction. Some men advocate immediate operation, while others would resort to every other measure first. That we may have some distinguished authority to guide us in this grave situation, we note Mr. Jonathan Hutchinson's closing remarks in the *Med. Press*, October 7. He says:

"I advise that very early in all cases of obstruction the attempt at what I have called the abdominal taxis should be done patiently and thoroughly, and then I would wait a long time. I would use belladonna, laxatives, repeated abdominal taxis. I would avoid injury. I would do a lateral operation, and as a last resort I may be driven to open the abdomen in the middle line, and do the best I can. If it be possible to cut into the bowels, and so empty them, then I think laparotomy has been very much simplified."

It seems to us, after reviewing the subject, that if we can make any kind of an accurate diagnosis as to the locality of the obstruction, early operative interference is called for, before the possibly incarcerated gut has had time to become gangrenous.

Intra-pulmonary Injections.

It is now some years (fifteen) since we first saw Dr. Wm. Pepper resort to intra-pulmonary injections of iodine in cases of phthisis. Since that time numerous clinicians have desperately resorted to this procedure, in the vain hope of successfully combating this fatal affection. We say desperately, not that the operation is a serious one, but because all hitherto tried remedial measures, save those that are *hygienic*, have proved valueless. Dr. Beverly Robinson, of New York, and Dr. R. Shingleton Smith (*Bristol Medico-Chirurgical Journal*, September, 1885,) (*Brit. Med. Jour.*, October 31,) have contributed to the subject about the

same results, and they both find that while these injections are harmless, producing no bad effects, they mitigate the symptoms, but have no radical effect on the progress of the disease in the majority of cases. Some patients gain weight, but the majority find only that the cough is relieved. As this procedure is not new, has been fairly tried yet fails to do much good, we fear it must be relegated to the useless shelf, save as a mitigant. Dr. Smith uses an ether solution of iodoform, one grain in five, or two grains in ten minims, injected every day or less often.

Foot-pain in Typhoid Convalescence.

A physician writes to the *Med. Press* (October 7) that he has a patient who is "convalescent, but a most unusual and distressing complication has set in. He has suffered for the past week from a most severe and constant pain on the dorsal surface of both feet. The slightest touch cannot be borne. He has tried local applications of ext. belladonna and glycerine, liniment of aconite and belladonna, etc., etc., but these remedies afford no relief. There is no oedema, nor any alteration whatever in the appearance of feet. Opiates give relief at night. The patient had hitherto been a healthy country lad, and had never had any other illness."

The editor thus answers him:

"Gently smear the following ointment:

R. Extract. aconiti et glycerini, aa $\mathfrak{z}\text{j}$.
Ung. hydrarg., ad., $\mathfrak{z}\text{j}$.
Fiat unguentum.

"Having smeared this ointment thickly on, wrap the feet up in a large poultice of very hot bran. Preserve perfect rest in the horizontal posture. A few days of this treatment will complete the cure. Should the pain in the meantime become intolerable, try hypodermic morphia."

Nephrotomy and Nephro-lithotomy.

In the *Brit. Med. Jour.*, October 31, Mr. Bennett May publishes the notes of three cases of nephrotomy and nephro-lithotomy, of which the following is a short abstract:

Case 1. Youth, aged 20; symptoms well marked; duration, fourteen years; incision made into kidney; calculi removed; free hemorrhage, which stopped only on firm plugging; subsequent perinephric suppuration; thrombosis; death from pyæmia in three weeks.

Case 2. Male, aged 35; symptoms of ten years' duration; small stone detected in kidney by acupuncture; operation; stone removed through very small incision; another larger stone after-

wards removed; rapid recovery; now able to do hard work; patient shown.

Case 3. Female, aged 23; symptoms well marked; eighteen months' duration; six weeks before, passed mulberry calculus *per urethram*; relief; subsequent relapse; operation; failure of palpation and acupuncture to discover stone; no stone found; rapid recovery, with relief of symptoms.

Insomnia Produced by Chloroform.

According to the *Brit. Med. Jour.*, October 10, 1885, M. Regnault has observed, from personal experience, that repeated inhalations of small doses of chloroform produce insomnia. M. Dubois has noticed the same effect in chronic intoxication from chloroform; the condition also provokes neuralgic or rheumatic pains, extending along the limbs, and sometimes attacking the articulations. Sleeplessness is preceded by a condition of excitement, redness of the face, then an inclination to sleep, and accommodatory asthenopia. Brain-work becomes impossible in consequence of incoherence of ideas. If at this period a power of sleeping remains, it is always broken by starts, just after violent exercise has been taken; the limbs are often cold and numb. At an advanced stage trophic disturbance is manifested; the nails become soft, bunions appear on the toes, the patient grows thin and pale, and the circulation becomes faulty. About three years later on, a circle of pain girds the waist, and profuse sweats appear, as well as all the symptoms indicative of serious anæmia.

Successful Neuroraphy.

Dr. Di Fede reported to the Royal Medical Academy of Rome (May 24th last) the case of a lieutenant in a cavalry regiment, who had paralysis of the right forearm, in consequence of a sword wound received in a duel. The cutaneous sensibility on the outer part of the wasted forearm was much impaired; so it was on the dorsum of the hand and of the first three fingers; and there was complete loss of power in the hand. Two months and a half after the injury, Dr. Di Fede cut down upon the divided radial nerve, revived the extremities, and united them with two fine catgut sutures. Sensibility returned the fourth day, but mobility only a month after the operation. Under the alternate use of the induced and constant current, the limb regained shape and power, so that the patient could write and do sword exercises with the injured limb. With the closed fist, extension and supination were perfect; but the

movements of extension of the fingers and abduction of the thumb were not so complete. The patient was presented to the Academy, and the case is said to be the first of nerve suture practiced in Italy.

Quillaja Bark in Emphysema.

In the *Cent. f. Klin. Med.* Kobert recommends senega as an expectorant in emphysema, in the second stage of acute bronchitis, in chronic catarrh of the lung, in broncho-blennorrhœa, and in the later stages of pneumonia. This drug, however, is dear, has a bad taste, and is badly borne by the stomach in many cases. A thorough investigation has informed the author that senega contains two active glucosides. On analysis of all similar drugs, he has found that the bark of quillaja saponaria molina contains the same alkaloids in five times the amount that senega does. Quillaja bark is only a tenth the price of senega root. The taste of quillaja is not unpleasant. On exhibiting the drug, the author found that—(1) it is better borne than senega; (2) the remedy is gladly taken, even by children, on account of its sweet taste; (3) its power as an expectorant is beyond question. A decoction of the strength of 5 in 200 was used, and a tablespoonful given to adults, a teaspoonful to children. It may be obtained from Gehe & Co., in Dresden-Neustadt.

Rupture of Male Urethra and Corpus Spongiosum During Coitus.

Dr. F. S. Watson reports a case of this curious accident in the *Boston M. and S. Jour.*, November 12, and thus formulates the treatment;

"The treatment to be adopted in such a case is, I think, emptying of the bladder *very slowly*, using several catheterizations and occupying a number of hours before all the urine be drawn off. An over-distended bladder should never be suddenly emptied.

"Subsequent catheterization at each call to micturate, each operation to be followed by irrigation of the urethra by an antiseptic solution, introduced through a retrojecting soft-rubber irrigator.

"If suppuration occurs and abscess formation takes place around the urethra, external incision, drainage, and cleansing of the wound.

"The passage of a full-sized steel sound or bougie, every few days, until such a time as the stricture formation calls for operation, and then the employment of internal urethrotomy, dividing the obstruction to the size of the urethra one has to deal with."

Gangrene and Arteritis in Typhoid Fever.

Typhoid fever is liable to many complications, the pathology of most of which is but ill understood. M. Bernheim has observed in the course of one year four cases of gangrene. He believes that gangrene may occur in external and internal parts of the body. Noma and gangrene of the diaphragm are given as examples. In his experience noma has not been influenced by antiseptic treatment. It is asserted that gangrene, presumably limited, of the viscera may occur without the production of recognizable symptoms—latent visceral gangrene. Such a proposition is by no means absurd. We have in medicine to do with a great many affections that are latent. There is another statement for which M. Bernheim is responsible: Arteritis, leading to painful gangrene, may exist without tenderness or obvious swelling of the affected vessel. He has apparently observed cases in which the middle coat of the artery has been remarkably vascular. The paper is full of interest, but the brevity of the report (*La France Médicale*, September 19,) precludes further information.

Cancer of the Breast: No Recurrence.

In the *Brit. Med. Jour.*, October 17, we read of a woman, aged 64 years, who complained of pain in her breast twelve years ago. Dr. Crerar observed all the present symptoms of hard cancer, including great pain and rapid progress of the disease. The breast was large; its removal at the earliest possible period was advised, and, meantime, opiates were administered. She declined to be operated upon, and expressed a belief that the medicine was curing her. Dr. Crerar undeceived her on this point, and pressed immediate extirpation of the diseased gland. The patient now decided to undergo the operation. Dr. Crerar removed the breast. The wound, which was extensive, healed well, and the patient remained free from the disease to this day. The interest of the case consisted in absence of recurrence, even twelve years after operation.

Herpes Following the External Use of Belladonna and Atropine.

Dr. M. Mackintosh reports this case in the *Brit. Med. Jour.*, October 17: "G. A., aged 40, was the subject of chronic rheumatism. Two months ago, he was ordered belladonna liniment for application to a painful knee-joint. The use of this was followed by an eruption of herpes, with a good deal of swelling over the seat of application of the liniment. Last week, he had an attack of iritis in the right eye, for which a solution of atropine was

used to dilate the pupil. Some of the solution ran over the cheek, and was, in a few hours, followed by an herpetic eruption of exactly the same character as had followed the use of the belladonna liniment. The swelling was so great that the eye was completely closed."

Chloride of Methyl in Neuralgia.

In *Lyon Méd.*, Vinay writes eulogistically of the value of methyl chloride spray in neuralgia. The method of treatment, which was introduced by Debove, consists in throwing on to the skin of the affected part a spray of chloride of methyl, which in a few seconds causes freezing. The pain is equal to or greater than that of the actual cautery, but soon passes off, leaving some superficial redness, which however subsides in a few days. Of 25 cases thus treated, 21 are said to have been cured after one or more applications, and the rest improved. In lumbago especially were the beneficial effects noticed. This method also cured cases which had resisted all ordinary therapeutic measures, including counter-irritants in various forms.

Prophylaxis of Calculus.

Dr. Charles B. Plowright concludes a paper in the *London Med. Times*, October 10, 1885, by saying that the facts above stated warrant us in recommending a more liberal consumption of salt by those who are in any way threatened with calculous disease, either by hereditary tendency or by premonitory symptoms—especially those at the two extremities of life who reside in calculous districts. Particularly does this apply to infants and young children—the former, of course, through the mother, for we know that sodium chloride is one of those salts which freely pass from the maternal system into the mammary secretion.

A Remedy for the Galvanic Taste.

Dr. Leslie Phillips thus writes in the *Brit. Med. Jour.*, October 17: "One of the material inconveniences of galvanization of the head and neck complained of by patients is the persistence of the galvanic taste. Although its duration becomes evanescent as 'tolerance' to the current is established, at first it lasts many hours, frequently all day, and spoils the taste of all food. A patient whom I, in conjunction with Dr. Saundby, am treating with galvanism, tells us that a little pinch of coffee chewed from time to time is an efficient antidote to this disagreeable sensation."

Cocaine Poisoning.

What a world this is! Already, within a few months of its introduction to the profession, we find the public commencing to dissipate with cocaine. Dr. J. S. Spear relates in the *Med. Record*, November 14, the case of a marine who administered, hypodermically, to himself cocaine, and presented all the symptoms of opium poisoning. He recovered. He had contracted the habit of using cocaine to allay a thirst for alcohol. He was truly "out of the frying-pan into the fire." Five grains, at intervals throughout one night, were taken.

Nitrite of Amyl for Gout.

Dr. A. D. Macdonald claims, in the *Med. Press*, October 7, that nitrite of amyl favors the elimination of uric acid, and that it is a rational therapeutic agent in gout when contra-indications for its use do not exist. If we can by its use procure a more than normal discharge of uric acid when an attack threatens, we will find it also prophylactic. Let our gouty readers try this remedy, and give us the result. It will make very important and useful reading.

Olive Oil as a Menstruum for Cocaine.

The *Med. Summary* tells us that Dr. Andrews, of New York, at the recent meeting of the American Ophthalmological Society, said that the plan of dissolving cocaine in oil seemed to insure longer contact of the remedy, and that a smaller quantity was required. But as the cocaine salts were not soluble in olive oil, the alkaloid was preferable, only requiring a few minutes of gentle heating in a water-bath to dissolve it.

Chloride of Rubidium.

Dr. Charles Richet, in a communication to the Académie des Sciences, describes the results of his experiments with chloride of rubidium. Its physiological effects are the same as those of chloride of sodium, but its toxic properties are only half those of table-salt. Dr. Richet, therefore, recommends the substitution of the chloride of rubidium for chloride of sodium in therapeutics.

—In several cases of night sweats in phthisis in which atropine, quinine, and ergot had proved unsuccessful, Dr. Westbrook obtained excellent results from pierotoxin. It was given by hypodermic injection in dose of one-half to one milligramme ($\frac{1}{2}$ to $\frac{1}{10}$ grain), gradually increased to three milligrammes. It was also efficacious when given by the mouth.

CORRESPONDENCE.

Prevention of Septicæmia.

EDS. MED. AND SURG. REPORTER:—

Five or six years ago I adopted the practice of giving chlorate of potassium to all of my puerperal patients, commencing the second day after delivery, and continuing at least five days, or, what I think a better guide, as long as there is any color to the lochial discharge.

In that time I have not had a single case of septicæmia amongst the patients I attended myself.

It is true, my patients have all lived in a village of not over fifteen hundred inhabitants or in the country. It is also true that during that time there has been no epidemic of erysipelas, scarlatina, or diphtheria in this vicinity.

The use of the remedy as a preventive of blood-poisoning in puerpera is not original with myself, but I have extended it to my surgical cases with like good results. There may not be any power in the potassium chlorate to prevent septicæmia, but prior to the time I commenced using it such cases were not infrequent among my patients, a number were dangerously ill, and I lost a few that I treated or assisted in treating. I usually administer the remedy as follows:

R. Chlorate potassium,
Aqua pura,

3j.
3 ij.

M. Sig.—Half teaspoonful every three or four hours.

It is not necessary to give it in large doses, as they are dangerous.

I have never resorted to intra-uterine injections, as some recommend, but have relied upon vaginal injections of warm water, with or without any disinfectant, as needed, as a matter of cleanliness.

The periodical fevers sometimes preceding, at others following confinement, should be interrupted as soon as possible. They are liable to arrest the lochial discharge, and that will cause septicæmia, unless prevented by proper treatment. I hope physicians, in large cities or localities where puerperal fever or septicæmia is prevalent, will try the chlorate of potassium, and report, that the profession may know whether it is a success or a failure.

Rensselaer, Ind.

ISRAEL B. WASHBURN,
M. D.

Cocaine in Hyperæsthesia of the Osteum Vaginæ.

EDS. MED. AND SURG. REPORTER:—

The case was one of hyperæsthesia of the osteum vaginæ and the entire vaginal canal, so severe as to defy even the most careful attempt at a digital examination, rendering the use of the speculum entirely impossible, on account of the contraction of the muscles, and the intense pain and agony almost causing convulsions. By the use of a five per cent. solution of the oleate of cocaine (prepared by McKesson & Robbins), applied by means of a c. h. pencil freely to the labia minora, the vaginal tract as far up as she could permit the pencil to be used (it even causing severe pain), and by saturating a small piece of cotton with the cocaine, leaving it about one inch

from orifice, for fifteen minutes, then making another thorough application with the pencil for five or eight minutes. After a rest of five, I was enabled to conduct the examination, both digital and with the speculum, without any further embarrassment or difficulty, the patient stating that she felt no pain whatever. I found endometritis, some slight displacement, and a flabby, relaxed condition of both uterus and vaginal walls, due no doubt to parturition, her babe being about six months old. I shall continue to use the cocaine during my examination, as it has proven a happy relief from pain to my patient, and enabled me to perform what I could not have done without the use of chloroform.

Weston, W. Va.

GEO. B. SIMPSON, M. D.

NEWS AND MISCELLANY.

The Medical Department of the University of Washington Territory.

The board of regents have completed the organization of a law and a medical department of the territorial university, located at Seattle. The following gentlemen were elected to constitute the medical faculty:

Thomas T. Minor, M. D., Professor of Principles and Practice of Medicine and Clinical Medicine.

Rufus Willard, M. D., Professor of Obstetrics and Diseases of Women and Children.

Edward L. Smith, M. D., Professor of Principles and Practice of Surgery and Clinical Surgery.

John Baker, M. R. C. P. and S. Ont., Professor of Chemistry and Toxicology.

Gideon A. Weed, M. D., Professor of Physiology and Hygiene.

C. H. Merrick, M. D., Professor of Materia Medica and Therapeutics.

L. R. Dawson, M. D., Professor of Descriptive and Surgical Anatomy and Histology.

John W. Waughop, M. D., Professor of Psychological Medicine and Diseases of the Nervous System.

John C. Sundberg, M. D., Professor of Ophthalmology, Otology and Laryngology.

J. S. M. Smart, M. D., Adjunct Professor of Clinical Surgery and Diseases of Genito-Urinary Organs.

L. R. Dawson, M. D., Demonstrator of Anatomy. Chair of Medical Jurisprudence to be filled.

L. J. Powell, A. M., President of the University, ex-officio member of the Faculty.

THOMAS T. MINOR, M. D.,
President of Faculty.

JOHN C. SUNDBERG, M. D., Secretary.

The course will cover three years, and will be graded. Students will also be required to pass a preliminary examination, or show other evidence of being in possession of a fair English education, before they can be admitted to the medical department.

The school will begin after this year on the first Monday in October, and continue for four months. There will also be a brief summer session.

A London Hospital Scandal.

London has a hospital scandal of large dimensions. The Homerton Hospitals are nominally under the charge of the Metropolitan Asylums Board, but really under a sub-committee of the board. This committee has allowed a state of things to grow up so bad that the *Spectator* says: "Even autocratic Russia or aristocratic England of the last century, or the debased democracy of Tammany Hall, could hardly beat the Homerton Hospital authorities in mismanagement and the consequent corruption." In fact, everybody seems to have done as they liked in the matter of supplies for the hospitals. Incredible quantities of wine and beer were ordered and divided for the most part among the doctors and other officers. The steward partly built and furnished a house out of hospital supplies. Verbal contracts were made for large amounts of material not needed. In short, the methods of the Tweed ring were adopted with a felicity and boldness quite phenomenal. The fault was in the Metropolitan Asylums Board, which delegated its authority to a perfunctory committee; but the promptness with which the hospital staff availed themselves of their predatory opportunities shows that in England as here the only certain way to prevent corruption is to make it impracticable.

Effects of Brightness and Colors on Vision.

A Russian observer, Dr. Kolbe, having made some researches on the effects of various degrees of brightness and of colored paper on the acuteness of vision, using for the purpose Snellen's tables, has come to the conclusion that acuteness of vision increases with the difference in brightness between an object and the ground upon which it is placed, but that this increase is not proportional to the difference, augmenting rapidly as long as the difference of brightness is small, then augmenting very slowly until a great difference in brightness is reached, when it again augments very remarkably. He also finds that the color of the ground, unless it is very intense, has little effect on the acuteness of vision. With regard to the fatigue occasioned to the eyes by paper of various colors, he finds that red and green papers produce more fatigue than blue and yellow, and these again more than grey and white of the same degrees of brightness. Altogether, he does not think that a colored paper for printed books presents any advantage, as far as the eyesight is concerned, over white paper.

The Mechanism of the Ribs.

In an important monograph on this subject, in the *Archiv für Anatomie und Physiologie*, Dr. Hermann von Meyer comes to the conclusion that the ribs are raised, so as to increase the antero-posterior diameter of the thoracic cavity during inspiration, chiefly by the segments of the external intercostals which lie between the vertebral attachments of the ribs and the angles of those bones, and also, as has long been recognized, by that portion of the internal intercostals which lies between the costal cartilages. The increase of the lateral diameter of the thorax is brought about by the rotation upwards of each rib, on a line which runs

from the costo-vertebral articulation to the sternum. This is the "bucket handle action," familiar to lecturers on physiology, demonstrators and students. According to Dr. von Meyer, this is effected by both the external and the internal intercostals—not, of course, by the whole of each of those muscles, but by the entire segment which lies between the angle of the rib and its cartilage.

An Interesting Case.

The following case, reported by Prof. Brouardel to the Society of Medical Jurisprudence, is interesting as being an example of a rare accident (rupture of the heart) in infancy, as well as from a medico-legal point of view. A child nineteen months old died with all the signs of strangulation. At the autopsy a rent was discovered in the anterior wall of the left ventricle of the heart, the other portions of the organ being filled with blood. The medical man who was called upon to report on the case certified that the child died from asphyxia, caused by strangulation, which was also the cause of the rupture of the heart. This, however, was considered a misinterpretation of the nature of the lesion, as Prof. Brouardel made out that the child had an ulcerous endocarditis, and an aneurism in the wall of the heart, which prepared it for the rent. He, moreover, added that rupture of a healthy heart can never take place after strangulation, but it is easily understood that it can occur in a diseased heart. The case being a most difficult one to decide, as to the share of culpability of the father of the child, who was accused of having strangled it, he was acquitted.

Results of the Continuation of Pasteur's Inoculations for Rabies.

The Paris correspondent of the *Lancet* writes that the young shepherd (Jupille) referred to as being still under observation, and upon whom M. Pasteur has since ceased his inoculations, has returned to his native village. His room is now occupied by another lad of fourteen, who is said to have been bitten by a mad dog at Bordeaux. Two other children, also bitten by a mad dog, have been forwarded to Paris by the Mayor of Roubaix, to be subjected to M. Pasteur's treatment for hydrophobia. The persevering and zealous experimenter will soon have his hands full, and the confidence in his remedy is such that people come from great distances to consult him, without even taking the trouble to find out whether the dogs that bit them were really rabid or not; so that M. Pasteur will, under the circumstances, have some difficulty in selecting his cases. Owing to the favorable results obtained by M. Pasteur, it is proposed to organize a special staff in different localities for the carrying out of his method, and that all medical men should be instructed as to the manner of its employment.

A Cotton Reel Seven Years in the Vagina.

Professor Breisky gives an account in the *Prager Medizinische Wochenschrift* of the case of a woman, who for seven years had suffered severe pain during menstruation, and, four years previously, had had an abscess in the inguinal region, which on

being opened, was found to contain a large quantity of pus. On examination, the vaginal mucous membrane was found greatly swollen, and the vagina itself seemed to come to an abrupt termination, no uterus being felt. On examination *per rectum*, a foreign body was made out, lying in a fluctuating sac behind the uterus, which was then felt displaced backwards. The patient, on being questioned, remembered introducing a cotton-reel seven years before. Under an anæsthetic, the vagina, which was so contracted by cicatrix as only to admit a probe at one spot, was dilated, and the reel drawn out. It was 1.35 inches long, and 1.15 inches in breadth. The contracted cicatricial portion of the vagina was kept distended, and some incisions made in it. The monthly periods became quite painless, and the patient made a good recovery.

The Law and Professional Evidence.

The *Med. Record*, December 5, 1885, notes that a daily paper announces that Dr. J. A. Milne, of Oswego, N. Y., was on November 25 fined \$250. with the alternative of six months' imprisonment, for contempt of court in refusing to testify in a criminal case. Dr. Milne pleaded as a defense for his refusal that his testimony would involve the disclosure of professional secrets. The law in New York, as well as in Arkansas, California, Indiana, Michigan, Iowa, Missouri, Minnesota, Montana, Ohio, and Wisconsin, is, that communications between physicians and patients which may relate to the history of a transaction in which a wound has been received, or a particular disease communicated, whenever essential to the treatment of a patient's case, are privileged. In New York it is even expressly enacted that the physician shall not disclose any information which he may have acquired in attending any patient in a professional character, and which information was necessary to enable him to treat the patient.

Official List of Changes of Stations and Duties of Medical Officers of the United States Marine Hospital Service, for the weeks ended December 5, 1885.

Wyman, Walter, surgeon. Granted leave to attend meeting of American Public Health Association, December 3, 1885.

Benson, J. A., passed assistant surgeon. Granted leave of absence for fifteen days, November 28, 1885.

Armstrong, S. T., passed assistant surgeon. Granted leave of absence for eight days, November 30, 1885.

Wasdin, Eugene, assistant surgeon. Granted leave of absence for thirty days, November 28, 1885.

Watkins, R. B., assistant surgeon. To proceed to Galveston, Texas, for temporary duty, November 30, 1885.

Unfiltered Water and Disease.

A striking example of the influence of drinking-water in the production of disease were lately observed at Rouen, where an epidemic of typhoid fever broke out in the 12th Cavalry. This regiment is lodged in new barracks, which were pro-

vided with non-filtered water from the Seine; forty of the soldiers were all at the same time under treatment in the hospital, and the medical officers of the regiment had no doubt in their minds that the water was the cause of the epidemic. They advised that the regiment should be immediately removed out to camp, which was put in execution, and the epidemic soon disappeared. By a singular coincidence, another epidemic of typhoid fever broke out among the garrison at Verdun under almost similar circumstances, when similar measures were adopted with equally good results.

Cholera Imported by Reapers.

The cholera was imported into the town of Montegudo, according to the *Independencia Médica*, by a party of reapers who came from Arragon. One of these was seized with cholera at the gate of one of the houses of the town, and vomited over some pitchers which were used (after being washed) for drawing water from the public well, having to be let down into the well for the purpose. In this way the well became a centre of infection, and in a very few days a violent "explosion" of cholera occurred, no less than 800 persons being attacked, 265 of whom died.

Philadelphia Polyclinic.

The Philadelphia Polyclinic and College for Graduates in Medicine will soon remove to its enlarged and improved building on Broad street. Its present quarters, at Thirteenth and Locust streets, are insufficient for its increasing classes of practitioners from all over the United States. Hospital wards and private rooms for patients will be opened, and the dispensary service will be given increased attention. The prosperity of the college has warranted this extension of its business. The journal edited by the faculty will be doubled in size after the first of the year.

The Physician's Pocket Record.

This useful pocket companion, published at this office, is now ready for 1886. Dr. A. B. Bowen, of Iowa, in ordering a copy, writes: "I have used your *Pocket Record and Visiting List* for fifteen years. It answers all indications better than any other I have seen."

Items.

—*Virchow's Archives* has commenced its one hundredth volume.

—Mr. East, in the *Brit. Med. Jour.*, December, 1884, gives a practical hint with regard to the treatment of phimosia. It is to use thin strips of gentian-root as wedges, inserting six or eight between the glans and prepuce.

—In the *Brit. Med. Jour.*, January, 1885, p. 209, Dr. Neale writes that he found a two per cent. solution of cocaine most useful in a case of excision of the uvula, in a sensitive girl. Two minutes after the use of the solution the patient was free from pain.

—Dr. Squibb suggests as a means of disguising the taste of bitter and nauseous salines a mouthful of ice-water just before and just after the dose; the saline itself to be taken in a wineglassful of iced water between them.

—In the *Brit. Med. Jour.* (May 2), Mr. J. J. Pickles relates a case in which a mother in three consecutive pregnancies gave birth to children the subject of hare-lip, there being no hereditary tendency or apparent cause for the deformity.

—Mr. Charles Edward Cormack, son of the late Sir John Rose Cormack, has graduated as Doctor of Medicine in the Faculty of Medicine of Paris. The subject of his thesis was "The Treatment of Chronic Empyema by Estlander's Operation."

—A young lady in Berlin recently asked a chemist for chlorate of potash for gargling, and was told to take a spoonful from time to time. She misunderstood the advice, for instead of taking it dissolved in water, she took the powder in spoonfuls undissolved, and died, after five days' illness, from vomiting and asthenia.

—Dr. A. M. Duncan, of Hamler, Ohio, writes to the *Med. Record* that Dr. Alvord, a retired practitioner of that place, who is a sufferer from glycosuria, finds more relief from a diet of pure buckwheat-flour cakes than from anything else. While he adheres to this food the urine becomes nearly normal in quantity and quality, there is no gastric distress, and the pain in the eyes—nearly destroyed by chronic iritis—is markedly relieved. On resuming the use of wheat bread and other starchy foods, the symptoms become aggravated, to be again relieved upon a return to buckwheat.

—M. Pierre Vigier (*Gazette Hebdomadaire*, February 6), states that for injection in gonorrhoea the lactate of quinine is the best preparation of quinine, owing to its greater solubility. His formula is lactate of quinine 1 gramme, distilled water 75, and glycerine 25 grammes. About 5 grammes should be injected three or four times a day. M. Vigier takes the opportunity of recommending practitioners to more and more employ the lactate in preference to any other preparation, whether for internal, external, or hypodermic use. It is the salt which is best adapted for every therapeutical application.

—Luschka has classified supernumerary mammary glands under two distinct divisions: mamma erratica and mamma aberrans. Mamma erratica is a true supernumerary mammary gland, developed on any part of the body, excepting its normal position, the front of the thorax. Mamma aberrans signifies a gland that lies on or near the pectoralis major, but has a distinct outlet for its ducts, separate from the true nipple. This condition is rare. Dr. Cohn exhibited a case before the Berliner Medizinische Gesellschaft, on February 25th. It was not an instance of milk-fistula, which generally arises from a wound, or from abscess. The patient in this case, it is true, had inflammation of the natural gland on the left side, and quite accidentally found out that milk dribbled away from the axilla. On careful examination, a duct was found opening in the axilla. It was covered with skin, and, on pressure of the integument around it, milk squirted out.

—Some time ago, Professor Virchow collated the results of an inquiry into the relative proportions of the blonde-haired, dark, and mixed types among the school children of the German Empire. Since then, the inquiry has been extended to Belgium, Austria, and Switzerland, embracing nearly eleven million children in its scope; and, in a recent lecture at the Berlin Academy of Science, Professor Virchow showed that more than fifty per cent. of the school children of Central Europe belong to the mixed type. The distribution of the purely blonde type, which contributes more than twenty-five per cent., and is associated with unmixed Teutonic blood, is highest in Hanover, where it forms forty-three per cent. of the population; but it is very nearly as high in the extreme East Prussian and Pomeranian districts, where history and tradition would indicate a preponderating Slavic element.

OBITUARY NOTICE.

DR. EPHRAIM CLARK.

Dr. Ephraim Clark, one of the oldest residents of Richmond county, New York, died on November 20th at New-Dorp, S. I. For thirty years he was the county physician. He was eighty-nine years old. He was the oldest medical practitioner on Staten Island, and had a son, Dr. James G. Clark, and a grandson, Dr. Frederick E. Clark, of West New Brighton. Dr. Clark was one of the physicians who attended Aaron Burr.

MARRIAGES.

AMIDON—FIELD.—November 21, 1885, in the Phillipsburg, N. J., Presbyterian church, by the pastor, Rev. H. E. Townsend, Royal W. Amidon, M. D., of New York city, and Emma D. F., daughter of Dr. C. C. Field, of Easton, Pa.

ESPY—NELSON.—October 29, 1885, at the residence of the bride's parents, by Rev. G. W. Chaifant, Dr. J. S. Espy and Miss Alice Nelson, both of the East End, Pittsburgh.

GROSS—WILLIAMS.—November 26, 1885, in Boston, by Rev. J. I. T. Coolidge, D. D., Ferdinand H. Gross, M. D., of Philadelphia, and Miss Frances A. Williams, of Boston. No cards.

RICHMOND—WHITNEY.—October 28, 1885, in Woodstock, Vt., at St. James' church, by Rev. F. W. Smith, Dr. Deane Richmond, of Windsor, and Miss Ellen A. Whitney, of Woodstock.

SHIELDS—BOWSER.—May 26, 1885, by Rev. J. M. Kelly, at the home of the bride's mother, William Shields, M. D., and Miss Nannie Bowser, both of Plumville, Pa.

WAY—MILBANK.—November 17, 1885, at Greenfield Hill, Conn., by Rev. G. S. Plumley, Dr. J. W. Way and Eleanor N., daughter of Isaac M. Milbank.

DEATHS.

BOCKEE.—November 26, 1885, at Poughkeepsie, N. Y., of apoplexy, Jacob Bockee, M. D.

CARPENTER.—October 25, 1885, in West Burke, Vt., Dr. W. W. Carpenter, aged 73 years.

CLARK.—November 23, 1885, at Belvidere, N. J., Samuel S. Clark, M. D.

FROTHINGHAM.—November 19, 1885, suddenly, in New York city, at his residence, Avenue St. Nicholas and 1590th street, Dr. William Frothingham.

LINDSLEY.—November 15, 1885, in Nashville Tenn., Dr. Van Sindeben Lindsley, aged 45 years.

LOY.—November 19, 1885, in Cincinnati, O., Dr. E. E. Loy, aged 32 years.